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**CAUSES OF POSTNATAL DEPRESSION:  
PERCEPTIONS OF RECOVERED WOMEN**

**LINDA LEWIS**

**Dissertation submitted in fulfilment of the  
requirement of the Degree of Master of Arts**

**Department of Psychology  
UNIVERSITY OF CAPE TOWN  
January 2002**

**Supervisor: Gillian Finchilescu**

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## ABSTRACT

Investigations into the causes of postnatal depression are, with few exceptions, quantitative in nature. Although there are psychological, interpersonal and sociocultural perspectives on postnatal depression, the medical one dominates in terms of academic, professional and lay understandings of aetiology. The medical model has produced a plethora of investigations into the causes of postnatal depression but has paid little attention to the insights of women who have experienced the condition. This study sought to redress this by exploring the causes of post-natal depression from a women-centred perspective. A feminist approach to postnatal depression was adopted. This approach has evolved largely as a critique of the medical model and is grounded in a more qualitative tradition.

Semi-structured, in-depth interviews were conducted with twenty women who had recovered from postnatal depression. Transcribed data from the interviews were thematically analysed to uncover the participants' attributed causes for their post-natal depression. A number of common themes emerged and could be broadly grouped under "interpersonal factors" (such as the impact of the woman's relationship with her own mother); "psychological factors" (such as the impact of unresolved issues and feelings of loss on the new mother) and "biological factors" (such as hormonal factors). The dominant theme that emerged from this study was that of "motherhood". Included under this heading were all those factors specifically associated with being a mother that were regarded by the women as being the cause of their postnatal depression (such as the experience of childbirth, breastfeeding and lack of sleep). At the core of this theme lay the realisation that motherhood was not what they had expected it to be. Their disappointment in not meeting their own expectations of motherhood contributed significantly to their postnatal depression. An interesting finding was that while many of the respondents located feelings of failure to live up to the "ideal image" of motherhood as a cause of their depression, few questioned the validity of the social construction of this ideal.

This paper also examined the extent to which women's aetiological explanations resonate with existing models of post-natal depression. Their explanations were found to reflect some of the existing aetiological models of postnatal depression but no single model of explanation could be identified as the cause of their postnatal depression. Rather, women's attributions of cause were multilayered and complex. They all attributed their depression following childbirth to a number of factors and they differed markedly from one another in their attributions. According to this research, postnatal depression results from a myriad of inter-related factors which interact with one another in different ways to produce a largely different picture for each and every woman.

The limitations and contributions of this study are discussed.

University of Cape Town

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## **CHAPTER ONE**

### **INTRODUCTION**

Cultural norms of Western society have led women to believe that the experience of childbirth and the puerperium is fulfilling, joyful and rewarding. Yet mood disorders associated with this period are far from newly identified syndromes. Unterman, Posner and Williams (1990) report that as far back as Hippocrates disturbances of cognition, function or affect have been associated with the childbirth experience. Research in the area of postnatal depression (PND) has been on the increase in the past two decades for the following reasons. Firstly, it is recognised that for many women childbirth represents a period of change and disruption not only on an intrapersonal level but also with regard to the woman's marital relationship and family and social roles (Gotlib, Whiffen, Wallace & Mount, 1991; Richards, 1990). Secondly, postnatal depression has been found to have adverse effects on the development of children both on a cognitive (Beck, 1992; Boyce & Todd, 1992; Cogill, Caplan, Alexandra, Robson & Kumar, 1986) and a behavioural level (Cox, Holden & Sagovsky, 1987). Finally, despite a high prevalence of depression following childbirth (Wrate, Rooney, Thomas & Cox, 1985), a definitive understanding of the aetiological factors contributing to the experience of unhappiness following childbirth is particularly lacking.

This research project aims to explore women's perceptions of the causes of postnatal depression. This will be achieved by interviewing women who have recovered from postnatal depression. The interviews will focus on their understanding of their experience and compare this to existing aetiological models of postnatal depression in the hope of developing a more holistic and coherent picture of the causes of postnatal depression.

## POSTPARTUM AFFECTIVE DISORDERS

The months following childbirth are frequently characterised by mood disturbances or more severe depressive episodes (O'Hara, Neunaber & Zekoski, 1984; Pitt, 1968). Three discrete postpartum syndromes, which are frequently confused or inadequately grouped together under the rubric of postpartum depression, have been identified (Gitlin & Pasnau, 1989). Each differ in terms of onset, severity, and duration of symptoms and each requires distinct interventions.

The least severe of the syndromes is what has been termed maternity or postpartum "blues". This is a mild syndrome experienced by an estimated 85% of women within the first few days after delivery and lasting for only a matter of days (Iles, Gath & Kennerley, 1989; Kennerley & Gath, 1986; O'Hara, Schlechte, Lewis & Varner, 1991; Troutman & Cutrona, 1990). Symptoms include "a normal state of sadness, dysphoria, frequent tearfulness, and clinging dependency" (Kaplan & Sadock, 1988, p. 23), mood lability, anxiety, insomnia, malaise and fatigue (O'Hara, Zekoski, Philipps & Wright, 1990; Troutman & Cutrona, 1990; Ugarriza, 1992). It is generally accepted that this transient minor affective disturbance is due to hormonal fluctuations that occur during pregnancy, delivery and the immediate postpartum period (Gitlin & Pasnau, 1989) as well as to the stress of childbirth and the awareness of the increased responsibility that comes with motherhood (Kaplan & Sadock, 1988). Although the experience of the blues may be distressing and unpleasant, there is little evidence of long-term negative consequences.

The most severe of the postpartum disorders is puerperal psychosis (Gelder, 1978; Kennerley & Gath, 1989; O'Hara, 1987; Troutman & Cutrona, 1990). The risk of psychosis increases substantially during the first three months postpartum (Kendell, Chalmers & Platz, 1987) and is experienced by approximately one to two women in every 1000 deliveries (Kaplan & Sadock, 1988; Kendell, 1985). Postnatal psychotic disorders fall into two categories: bipolar depression and major depression. Women experiencing the mania of bipolar depression after birth suffer from irritability, hyperactivity, euphoria and grandiosity while those experiencing the depression of bipolar disorder or major depression report symptoms of tearfulness, preoccupation

with guilt, feelings of worthlessness, psychomotor retardation, and sleep and appetite disturbances (Ugarriza, 1992). Delusions about the infant being dead or defective are common as well as reports of hearing voices that command the mother to harm the baby (Landy, Montgomery & Walsh, 1989).

A third syndrome of moderate severity is nonpsychotic postpartum depression or what is appropriately termed postnatal depression. It is this syndrome which is the focus of this research. It is marked by its insidious onset with symptoms occurring at least two to four weeks after delivery. Most episodes resolve within six months, although it can last up to four years (Cooper, Campbell, Day, Kennerley & Bond, 1988; Kumar & Robson, 1984). Symptoms include a dysphoric mood along with sleep, appetite, or psychomotor disturbance; fatigue; excessive guilt; and suicidal thoughts (American Psychiatric Association, 1994).

A number of studies have investigated whether depressions that occur after childbirth may show a different symptom pattern from depressions that occur at other times. Certain characteristics of postpartum depression are remarkably similar to nonpostpartum depression e.g., feelings of inadequacy, anxiety, despair, lack of energy, loss of sexual interest, compulsive thoughts, fatigue, poor memory, irritability and so on. What Pitt (1968) argues is “atypical” of postnatal episodes of depression is prominent neurotic symptoms such as anxiety, irritability, or phobias, which tend to overshadow the depression. However, Cooper et al. (1988) found no support for this view when comparing the symptom picture of depressed childbearing and nonchildbearing women. Beck (1992) argues that it is the contents of the mother’s thoughts which are atypical of “normal” depression. These thoughts focus on the mother’s sense of incompetence in being able to care for and love her baby as well as her ambivalence towards the infant (Beck, 1992). This suggests that it is the cognitive-affective changes which provide the clarity needed to identify postnatal depression. Cooper (1997) argues, however, that “too little research has addressed this question for us to be confident that postpartum depression does not present in some distinctive fashion” (p.11).

Whilst it has been claimed that three discrete postnatal syndromes can be identified, some researchers have argued for a continuum rather than a dichotomy perspective. This perspective allows women to express a range of positive and negative feelings following the birth of a child, without receiving a diagnosis of illness (Elliot, 1984; Usher, 1992a). The question arises as to whether this “condition” should be construed as a psychological disorder or whether it should be understood as falling within the normal boundaries of psychological and physical adjustment elicited by childbirth. Are symptoms such as tiredness, sleep and appetite disturbance, lack of sexual interest and energy as well as serious concerns about the well-being of the baby indices of appropriate and “normal” emotional adjustment following childbirth or are these symptoms of psychiatric disorders? This debate around the “normality” of postnatal depression is expanded on in greater detail by feminist researchers and authors and will be addressed later in this thesis.

## PREVALENCE

Great discrepancies exist in the literature with regard to the prevalence of postpartum depression because of the different diagnostic criteria used, the population studied and the length of the postpartum period under evaluation (Milgrom, Martin & Negri, 1999; O’Hara & Swain, 1996; Trad, 1994). Prevalence figures of less than 8% have resulted from sampling women who seek psychiatric care in the first postpartum year and are therefore likely to be severely depressed (Dalton, 1971). Intermediate figures of 8-20% have been reported from samples of women who meet the standard diagnostic criteria for clinical depression (O’Hara et al., 1991; Paykel, Emms, Fletcher & Rassaby, 1980). Elevated figures of up to 35% have been reported from studies which have used symptom checklist data only and have not employed specific diagnostic criteria (Campbell & Cohn, 1991). As Milgrom et al. (1999) argue, the more stringent the diagnostic criteria, the lower the prevalence rate for postnatal depression.

Many women suffer from postnatal depression, which can be regarded as one of the most disabling of postpartum complications. Yet few women either seek help or are detected as being in need of help for their emotional problems even though the

postpartum period is usually characterised by repeated contact with health professionals (Kumar & Robson, 1978). Nicolson (1990) argues that this situation arises because both lay people and professionals equate motherhood with “happiness”. Since women are expected to be happy at this time of their lives they seldom feel justified in admitting to their feelings of distress lest they be judged “abnormal” by the professionals who are attending to them. Yet postnatal depression is not uncommon and its impact on a woman’s life and relationships can be particularly devastating.

### **South Africa**

While the medical profession in South Africa provides treatment for pregnant and postpartum women, it does not seem to pay adequate attention to the psychological impact of childbirth and its consequences on the new mother. This lack of awareness amongst practitioners has been recognised by women who have suffered from postnatal depression and has given rise to the Postnatal Depression Support Association (PNDSA). PNDSA was established in 1997 and is the first of its kind in South Africa. It offers information, counselling, referrals and support to women (and their families) who experience depression both during and after the birth of a child. That it has filled a vital gap in the postnatal mental health arena in South Africa is evidenced in the numbers of women who make use of the organisation. Since its inception the PNDSA Helpline has received over 3000 calls and over 3500 women have attended workshops. A further 300 women have attended the postnatal depression support groups (PNDSA Newsletter, 2001). PNDSA provides a safe and legitimate space for women to come forward and seek help for their postnatal depression and share their experience rather than feel that it is an unusual syndrome and one to be ashamed of.

Many women in South Africa suffer from postnatal depression. The local South African research efforts in the field of postnatal depression are beginning to reflect this. For the main part, local research has focused on risk factors associated with postnatal depression. The main risk factor which has been investigated and found to impact significantly on postnatal depression has been that of social support

(Hargovan, 1994; Morgan, 1992; Spangenberg, 1994; Trotter, 1992). Other risk factors which have been researched include personality and life events (Hargovan, 1994); previous history of depression, marital satisfaction and life stress (Morgan, 1992) and psychosocial factors such as the mother's relationship with her partner and mother, her emotional well-being during pregnancy and her level of preparedness for motherhood (Mills, Finchilescu & Lea, 1995).

The most extensive study conducted to date in South Africa has investigated the prevalence of postnatal depression and its impact on the mother-infant relationship in the peri-urban settlement of Khayelitsha (Cooper, Tomlinson, Swartz, Woolgar, Murray & Molteno, 1999). 147 women were assessed for postnatal depression two months after giving birth and the quality of their engagement with their infants was determined. It was found that the rate of postnatal depression in this sample was three times that found in British postpartum samples, with an incidence rate of 34.7% (assessed according to the diagnostic criteria cited in the Diagnostic and Statistical Manual of Mental Disorders IV, (American Psychiatric Association, 1994)). Maternal depression was associated with poor emotional and practical support from the fathers of the children as well as insensitive engagement with the infants on the part of their mothers. More specifically, compared to non-depressed mothers, the depressed mothers showed less sensitivity in their interactions with their infants. Furthermore, the infants of depressed mothers were less positively engaged with their mothers. This study highlights the high prevalence of postnatal depression in this community as well as the need for intervention so as to ameliorate the disturbances in the mother-child relationship.

## **CHAPTER TWO**

### **CAUSATIVE FACTORS**

While a number of causative factors have been implicated in the development of postnatal depression, research in this area has not produced any clear consensus on aetiology. Nevertheless, a review of the literature reveals various perspectives with regard to aetiology. These perspectives can be grouped under four main headings:

#### **1. Biological factors**

- a. hormonal/chemical factors
- b. hereditary factors
- c. previous depression
- d. childbirth

#### **2. Psychological factors**

- a. personality factors
- b. psychodynamic perspective

#### **3. Interpersonal factors**

- a. spousal and social support
- b. relationship with own mother
- c. infant variables

#### **4. Sociocultural perspective**

## **BIOLOGICAL FACTORS**

Biological factors refers to those theories on the aetiology of postnatal depression that are essentially related to the physical body, be it hormonal or chemical factors, genetic factors or the physical act of childbirth itself.

### **Hormonal/ Chemical factors**

Some researchers state categorically that postpartum mood disturbances are organic mood syndromes – i.e., that a specific organic factor is aetiologically related to mood disorders and that for the majority of women suffering from postnatal affective syndromes there is an organic basis to the illness (Lipowski, 1980; McKenzie & Popkin, 1983; Young, 1984). Organic aetiological explanations for postnatal depression are based on the major physiological changes associated with childbirth and the high incidence of “mental illness” in the first fortnight following delivery (as is typical of what was described earlier as postpartum blues).

The high prevalence of postpartum blues in addition to its temporal relationship to childbirth (onset occurs within the first two weeks post delivery) lends credibility to the claim that a biological factor associated with childbirth could be an important precipitant of emotional disturbances. Further indirect evidence of a biological basis to postnatal depression consists of an association between menstrual difficulties and postpartum mood alterations (Dalton, 1971; Pitt, 1968). According to this hypothesis, as will be discussed below, postnatal depression results from a failure to adjust physiologically to the massive hormonal changes following delivery (Hopkins, Marcus & Campbell, 1984). That is, women who are particularly sensitive to the minor hormonal changes that take place during menstruation will have greater difficulty adjusting to the major hormonal changes that occur during parturition.

However, theories purporting the relevance of organic factors to postpartum blues and postnatal depression remain to a large extent speculative because findings tend to be inconsistent and direct measures of hormonal levels and mood have failed to provide a link between these two variables (Hopkins et al., 1984; O’Hara, 1987; Pfof, Stevens & Lum, 1990).



Nevertheless, what follows is a discussion on the numerous biological theories that have been postulated as relevant to the development of postnatal depression. Greatest support for the biological causes of postnatal depression have come from studies on estrogen and progesterone imbalances (e.g., Dalton, 1971; Pitt, 1968; Pitt, 1978; Zare-Parsi & Hoffman, 1989) and on thyroid disorders (Amino et al., 1976; Fung & Kologlu, 1988; Harris et al., 1989; Harris et al., 1992).

### ***Hormonal***

Hormonal hypotheses relating to the onset of postnatal depression have been triggered by the observation that many women are affected by hormonal fluctuations through the pre-menstrual and menstrual period (O'Hara et al., 1991; Pitt, 1968; Pitt, 1978; Zare-Parsi & Hoffman, 1989). One study found that women who suffer from postpartum blues had a younger age of menarche, shorter length of menstrual flow and greater menstrual difficulties than a control group of non-depressed women (Yalom, Lunde, Moos & Hamburg, 1968). Considering the fact that imbalances in estrogen and progesterone levels during the menstrual cycle elicit emotional reactions, the significantly greater changes during pregnancy and after labour are even more likely to have a profound emotional effect on women. In fact, since labour is inevitably followed by a drop in levels of estrogen and progesterone, which is a possible cause of depression, it has been suggested not only that affective disorders may result from a failure of adjustment to these hormonal changes, but that, indeed, "it is the normal adjustment to such sudden alterations in hormone levels which is remarkable, rather than the occasional failure" (Gelder, 1978, p. 80).

Some hormone studies, however, have found no significant differences in hormonal levels between women with postnatal depression and normal controls (O'Hara et al., 1991; O'Hara & Zekoski, 1988). A prospective study by Davidson (1972) failed to find any association between the occurrence of mild or severe postpartum blues and previous menstrual difficulties (such as age of menarche and menstrual dysfunction). O'Hara (1980) also failed to find a relation between menstrual difficulties and postnatal depression (cited in Hopkins et al., 1984). This can possibly be explained by

the fact that some women are more sensitive to fluctuations in hormonal levels than others or that women may differ in terms of the threshold at which they begin to report minor degrees of discomfort (Gelder, 1978).

### ***Thyroid function***

Since thyroid disorders are associated with mood disorders (Kleiman & Raskin, 1994; Mallett et al., 1995), a further suggestion has been put forward: that postnatal depression may be accounted for in terms of thyroid dysfunction during the postpartum period. Thyroid antibodies, such as microsomal, thyroglobulin and thyroperoxidase, can be produced by the body during pregnancy and can attack the thyroid causing it to function abnormally (Harris et al., 1989; Mallett et al., 1995). A recent study, for example, found that thyroperoxidase antibodies during pregnancy were associated with subsequent depression during the postpartum period (Kuijpers, Vader, Drexhage, Wiersinga, van Son & Pop, 2001). A number of other studies have shown that in women who are thyroid antibody positive in the eight months following delivery (i.e., some form of thyroid antibody is detected in their blood), there is an excess of depressive symptoms and cases of depression overall (Fung et al., 1988; Harris et al., 1989; Harris et al., 1992). Several possible biochemical explanations could account for these results but these will not be covered here. Suffice to say that thyroid dysfunction in postpartum women is not uncommon. Women who present with postnatal depressive symptoms should be assessed for abnormalities in thyroid functioning because the latter could present as features of depressive syndromes but can be treated effectively with thyroid medication.

### ***Other biochemical factors***

Changes in adrenocorticosteroid hormone levels, including cortisol, have been cited as potential causes of postpartum depression (Gelder, 1978; Handley, Dunn, Waldron & Baker, 1980). Both free and bound cortisol are elevated during late pregnancy, peak at high levels during labour and drop again to pre-pregnancy levels after delivery.

This overproduction and sudden withdrawal is thought to be causally related to postnatal depression (George & Sandler, 1988).

Tryptophan changes have also been studied in relation to postnatal depression (Harris et al., 1989). 5-hydroxytryptamine (5HT), a derivative of brain tryptophan, may be decreased in severe depressive episodes. Handley et al. (1980) reported that among the normal women they studied between the second and fifth postpartum day, low unbound tryptophan concentration was associated with depressed mood. They caution, however, that such a correlation does not prove a causal relationship between low tryptophan levels and postnatal depression.

Despite extensive research into the biochemical origins of postnatal depression, no conclusive findings have been reported. Furthermore, this model does not account for the variability of postnatal depression. In other words, not only does it fail to account for why some women suffer from postnatal depression while others do not but it also does not account for those women who experience postnatal depression with greater intensity than others. Cooper (1997) questions whether this situation results from the wrong hormones being studied or perhaps the complex interaction between hormones, neurotransmitters and other biological factors not being adequately captured. Finally, he argues that hormonal factors may only be relevant to those women who are otherwise vulnerable to affective disorders be it through hereditary factors (reflected in a personal or familial history of depression), psychological factors (e.g., personality traits such as optimism versus pessimism) or social factors (e.g., a poor relationship with one's partner or mother). Each of these factors will be discussed below.

### **Hereditary Factors**

Genetic factors may play a significant role in the development of postnatal depression in that a family history of depression may put one at increased risk. Indeed, Reich and Winokur (1970) found a one in three risk of a mother developing a postnatal mental illness if there was a previous history, as well as a family history of psychiatric disorder. Similarly, in Meltzer and Kumar's (1985) study, about 50% of women with postpartum depression had a positive family history of mental illness.

## **Previous Depression**

A woman's previous psychiatric history and mental state has also been found by some researchers (Kelly & Deakin, 1992; O'Hara et al., 1991; Paykel et al., 1980; Wolkind & Zajicek, 1981) but not others (Cox, 1986; Kumar & Robson, 1984; Pitt, 1968; Spangenberg & Pieters, 1991) to be related to the development of postnatal depression. Kelly and Deakin (1992), for example, studied 100 pregnant women from their 36<sup>th</sup> week of pregnancy to two months postpartum and found that early postnatal depression was significantly associated with a continuation of depressive symptoms during pregnancy. Similarly, Pfost et al. (1990) and Gotlib et al. (1991) concluded from their studies that the best predictor of postnatal depression was the level of antepartum depressive symptoms in their subjects. Finally, O'Hara et al. (1991) found that the risk of postnatal depression increased according to the levels of depressive symptoms during pregnancy, the existence of a previous depressive episode, the prevalence of a history of premenstrual tension, and the existence of a first-degree relative who had been diagnosed with depression. Thus, it is argued, a previous history of depression in the postpartum woman is a significant risk factor especially when the depressive episode developed during the pregnancy.

## **Childbirth**

While childbirth may be one of the most fulfilling and miraculous experiences in a woman's life, it is also an extremely stressful life event (Kendell, 1978). Like other stressful life events, childbirth may be a catalyst for eliciting vulnerabilities in some women, rendering them more susceptible to depression in the postpartum period. Some studies highlight the difficulties associated with childbirth which may trigger depression in already vulnerable women. For example, the popular Lamaze classes for a "painless childbirth", explicitly promise that prepared childbirth training will diminish labour pain (Lamaze, 1970). Research, however, shows that this promise is unrealistic and while prepared childbirth may lessen pain, the pain still remains severe (Melzack, Kinch, Dobkin, Lebrun & Taenzer, 1984; Melzack, Taenzer, Feldman & Kinch, 1981). Melzack (1984) argues that "the myth of painless childbirth" is precisely that – a myth - and women should be informed about this prior to childbirth

in order to bring their expectations of the childbirth experience more in line with reality. By doing this, women may stand a lesser chance of suffering from postnatal depression (Logsdon, McBride & Birkimer, 1994). This does not only apply to vaginal deliveries but also to Caesarean sections which are the most serious form of intervention during childbirth.

A number of studies have found a positive correlation between Caesarean section and postnatal depression (Boyce & Todd, 1992; Edwards, Porter & Stein, 1994; Entwisle & Doering, 1981; Kendell, Rennie, Clark & Dean, 1981; Romito, 1990). This relationship can be explained in a number of ways: Garel, Lelong & Kaminski (1987) found that women who have Caesarean sections often have a delayed initial interaction with the baby; that the mothers experience so much pain that it is difficult to enjoy contact with the baby and that the overall experience of childbirth was rated as much more negative than women who had a vaginal delivery. Edwards et al. (1994) attribute the relationship between Caesarean section and postnatal depression to a number of factors. In the first place, the anxiety associated with Caesarean sections may make women more vulnerable to postnatal depression. Secondly, a common factor to both postnatal depression and Caesarean section is lower social class and severe poverty may be linked to higher rates of Caesarean section. Thirdly, general anaesthesia for Caesarean sections may precipitate depression through some biological mechanism. Finally, the stress of an operation may render women more vulnerable to postnatal depression than would otherwise have been the case had they not had a Caesarean section.

Whether one has a vaginal delivery, minor obstetrical intervention or a Caesarean section, what seems to help women come to terms with the childbirth experience is not only adequate information before delivery but also an honest presentation of the realities of the pain and trauma associated with childbirth. As Romito (1990) states, the more informed patients are, the more positive the outcome.

## PSYCHOLOGICAL FACTORS

### Personality Factors

Research has led to a search for individual psychological determinants of postnatal depression. Carver and Gaines (1987) found that women in their study were more likely to experience postnatal depression if they were pessimistic. Optimism, they argue, is associated with active problem-focused coping and with the seeking of social support whereas pessimism is associated with a tendency to give up and disengage from goals, with a focus on the negative feelings elicited by the stressor – in this case, childbirth.

Other studies have linked postnatal depression to women who are obsessive, overcontrolled and perfectionistic (Albright, 1993). Hopkins et al. (1984) explain this by saying that women who are perfectionistic and controlling tend to have unrealistic expectations of their ability to mother children, and when they fail to meet these expectations they experience feelings of guilt, failure and inadequacy.

Locus of control has also been linked to postnatal depression – women with an external locus of control are more susceptible to depression because they perceive themselves as less in control of their lives which may make them adopt an attitude of “learned helplessness” (Seligman, 1975 cited in Hopkins et al., 1984). Another study conducted by Schroeder (1985) linked locus of control during the birth process to postnatal depression. He claims that women whose ideal expectations of labour and delivery are not met have more difficulty in assuming the role of a nurturing caregiver because her self-esteem is lowered by her self-perceived unsatisfactory labour. According to Logsdon et al. (1994) it is the unexpected which appears to be unsettling and which leads to loss of control. Clearly it is the relationship between mastery (personal control) and depression which is significant here.

Other personality factors which have been linked to postnatal depression include neuroticism or poor social adjustment (Kennerley & Gath, 1989), attributional style (Cutrona, 1983) and trait anxiety and fear of the birth process during pregnancy (Knight & Thirkettle, 1987).

## **Psychodynamic Perspective**

Numerous psychoanalytic explanations have been hypothesised. For example, postnatal depression has been associated with rejection of the maternal role and guilt over pregnancy (Bos, 1950). Others have claimed that postnatal depression arises from the mother's need to be an only child and her unconscious reaction to the baby as a rival sibling (Wayne, 1952). Despite the overt differences in these psychological formulations, what most of them seem to have in common is the notion of the mother being unable to accept the full implications of her maternal role. Pregnancy and childbirth may thus reactivate previously repressed traumas which result in a certain amount of "unacceptable" feelings being projected onto the newly born child. The anxiety provoked by these feelings is then relieved through various defence mechanisms such as depression or, in extreme cases, psychosis. It seems that a compounding of such psychological traumas with even a small amount of stressful experiences, which are typical of the postpartum period, can render new mothers extremely vulnerable to depression in the weeks and months following childbirth.

## **INTERPERSONAL FACTORS**

### **Spousal and Social Support**

Social support plays a very important role in buffering the impact of life events and stressors. Childbirth, as mentioned above, is one such stressful life event and social support, particularly from one's partner both during and following childbirth, is associated with reduced risk of postnatal depression (Cox, 1988; Dimitrovsky, Perez-Hirshberg & Iskowitz, 1987; Gjerdingen & Chaloner, 1994a; Gotlib et al., 1991; Lee, 1997; Logsdon et al., 1994; Mauthner, 1998a; Mills, Finchilescu & Lea, 1995; O'Hara et al., 1990; Paykel et al., 1980; Robinson, Olmstead & Garner, 1989). Cox (1988), however, states that it is difficult to establish the extent to which marital difficulties are a cause or a consequence of postnatal depression. Nevertheless, it is clear that following the birth of a child, the nature of the marital relationship within the context of a changing and dynamic family system requires a readjustment of sorts. Obvious examples of where new shifts and modifications have to be negotiated

include the co-operation of both parents as a team in taking care of the child as well as the changing nature of their sexual relationship as a consequence of postpartum complications or severe exhaustion on the part of the mother (O'Hara et al., 1990). Numerous other factors have been shown to impact negatively on the marital relationship such as a lack of emotional and practical support from partners in household and childminding tasks (Gjerdingen & Chaloner, 1994b; Paykel et al., 1980; Small, Brown, Lumley & Astbury, 1994); poor communication with the husband resulting in an inability to express one's problems and feelings around motherhood (O'Hara, 1986); a discrepancy between the mother's expectations and actual experience of closeness to her husband (Logsdon et al., 1994); and the perception that husbands spend longer hours at work and are less available for their wives (Mills et al., 1995).

While most studies investigating the importance of social support in preventing postnatal depression emphasise the role of the husband almost exclusively as the source of social support (Logsdon et al., 1994; Richman, Raskin & Gaines, 1991; Small, Astbury, Brown & Lumley, 1994), others draw attention to social support from those other than one's partner such as a close confidant (O'Hara, 1986), relatives and friends (Collins, Dunkel-Schetter, Lobel & Scrimshaw, 1993; Gjerdingen & Chaloner, 1994b; Gjerdingen, Froberg & Fontaine, 1991) and other mothers in similar situations (Mauthner, 1995, 1998b).

Collins et al. (1993) make the distinction between available support and actual support received. Potential available support concerns a person's general perception or belief that people in their social network would provide assistance in times of need. Actual received support refers to supportive exchanges that have actually occurred within a specific context. Received support, clearly being the critical factor, also differs in nature and in the postpartum period emotional as well as instrumental support from one's social network is most important. Furthermore, the way in which the support is given has also proved crucial in terms of its beneficial effects. Support, it is argued, should be given with consideration to the mother to ensure that, firstly, she is not disempowered and made to feel ineffectual in her own abilities and, secondly, to avoid creating a situation where she is made to feel indebted for the support she receives i.e., conditional support.



Bearing in mind these various factors, and the influence of a mother's attitude on the degree of social support she receives, health care providers can play a unique role in educating prospective parents about the importance of social support following childbirth. They may also play a critical role in mobilising support systems for new mothers (Gjerdingen et al., 1991). Indeed, Mauthner (1995) found that the extent and nature of mothers' contacts with other mothers of young children played an important role in mothers' feelings of well-being on a psychological and emotional level. She states that, "feelings of isolation from other mothers through depressed mothers' own social withdrawal from these women were associated with the onset of depression. Conversely, the mothers linked their journeys out of depression to the renewal of these relationships" (Mauthner, 1995, p. 311).

### **Relationship With Own Mother**

From the psychodynamic point of view, childbirth represents a major change in a woman's life – a change that demands considerable emotional adjustments. Not only does the new mother have to establish an entirely new bond with her baby, but she also has to renegotiate her relationship with her husband and her own mother. Psychoanalysts such as Deutsch (1947) regarded the pregnant woman's relationship with her mother as central to her problems in relating to her newborn child. More specifically, Deutsch (1947) has drawn attention to the process of identification that often occurs during childbearing between the mother and her baby, as well as with her own mother, saying that a woman with a hostile relationship towards her own mother may find this identification makes it difficult to be a "good enough" mother herself. The conflict may then be projected onto the baby who is consequently regarded as unwanted. Support for this claim has come from a number of retrospective studies. Wolkind and Zajicek (1981), for example, found that mothers who were themselves deprived of attention in childhood had greater difficulty accepting their maternal role. Another study, furthermore, showed that women with poor relationships with their own mothers were more likely to suffer from postpartum psychiatric disorders (Cox, 1986).

## **Infant Variables**

The infant, it has been argued, may represent a source of stress for the mother that may contribute to postnatal depression. For example, premature infants (Gennaro, 1988) and high-risk infants (Blumberg, 1990) have been implicated in the development of postnatal depression. Of greater importance from a social science perspective, however, is the impact of a poor match between the child's temperament and the mother. The mother may lack positive reinforcement for her caretaking because of her inability to read her child's cues. A flawed interaction resulting from this may contribute significantly to feelings of frustration, anger and depression (Herz, 1992).

Another infant-related variable which has been associated with postnatal depression is breastfeeding. Romito (1990) investigated the impact of breastfeeding on postnatal depression and found that women who had planned to breastfeed yet failed to do so due to inverted nipples, breast engorgement, a baby who does not want to suckle and problems associated with obstetrical intervention, such as Caesarean section were more susceptible to depression following childbirth. However, none of the women who had planned to bottle-feed before giving birth experienced depression. Furthermore, Romito (1990) as well as Alder and Cox (1983) and Alder & Bancroft (1988) found that women who were successfully breastfeeding were more at risk for postnatal depression than non-breastfeeders.

Various interpretations for this are presented. Romito (1990) argues that breastfeeders may experience more exhaustion than non-breastfeeders since not only do they have to do all the feeding for the baby both during the day and at night but breastfed babies have been shown to require more feeds than bottle-fed babies and tend to be more colicky and cry more. In addition to the tiredness, breastfeeders are more isolated than bottle-fed babies for a number of reasons: firstly, mother's cannot share the task of breastfeeding with others; secondly, the time and length of feeding from the breast is less predictable than bottle-feeding and thus it is more difficult for women to go out without their child or to plan their day; finally, breastfeeding mothers resume their

sexual activity later and less frequently than bottle-feeding mothers which can contribute to estrangement between spouses after childbirth (Romito, 1990). Alder and Bancroft (1988) found that breastfeeding mothers scored significantly higher on the social dysfunction, anxiety and insomnia scales and, like Romito (1990) attribute this to the practical consequences of breastfeeding rather than any direct effect on mood.

## **SOCIOCULTURAL PERSPECTIVE**

Stern and Kruckman (1983) attribute the development of postnatal depression to the absence of rituals in most of Western Society surrounding the birth of a child. In non-Western societies they observed six elements that are generally present in the structuring of the postpartum period: (1) cultural recognition of a distinct postpartum period, during which normal duties of the mother are interrupted; (2) protective measures designed to reflect the vulnerability of the new mother; (3) social seclusion; (4) mandated rest; (5) assistance with tasks, mostly from other women; and (6) social acknowledgement of the new status of the mother through rituals, gifts or other means. The authors claim that, in Western cultures, it is because of the relative lack of social structuring of postpartum events and the failure to recognise and accommodate for the role transition of the new mother, as well as the lack of practical assistance, that the postpartum mother is likely to become depressed. This depression would arise not only out of a lowering of the mother's self-esteem, causing uncertainty about the availability of support but also because of the likelihood of extreme fatigue as well as other postpartum stressors. Thus Stern and Kruckman (1983) argue that postpartum depression is a culture-bound syndrome found only in Western societies in which cultural factors shape and support depressive symptomatology. Harkness (1988) supports this conclusion, arguing that women in her study in Kenya seemed to show no evidence of postnatal depression. She concludes that "culture is a powerful mediating factor between the physiological processes related to childbirth and their psychological outcomes" (Harkness, 1988, p. 194).

In order to explore this claim, Cox (1986) investigated the prevalence of postpartum mental illness in the Ganda, the largest tribe in Uganda. What he found was that the

Ganda have a traditional puerperal mental illness called “Amakiro”. The symptoms of Amakiro most commonly reported include the mother’s desire to eat her baby, restlessness and mental confusion. Furthermore, the illness is thought to be caused by the mother’s promiscuity during pregnancy. These findings show that postnatal depression could be identified in a non-Western African culture and, in addition to this, that some of the symptoms of Amakiro could be interpreted as being similar to those described by Western women. Thus, contrary to Stern and Kruckman’s (1983) and Harkness’ (1988) claims, postnatal depression is not restricted to specific cultural contexts and thus cannot be construed as a cultural artefact. However, Cox (1988) appropriately warns that “when these sociocultural explanations of postnatal depression are overstated to the exclusion of intrapsychic and biological considerations, then they lack credibility” (p. 80).

The above chapter has outlined the various theories which have been put forward to explain the development of postnatal depression. These theories range from a purely medical approach to a psychological or sociological approach, and finally to a broader cultural perspective on postnatal depression. The following chapter offers a critique of the dominant aetiological model of postnatal depression – the medical model – and presents the feminist model as an alternative framework within which postnatal depression can be better understood.

### **CHAPTER THREE**

#### **THE MEDICAL VERSUS THE FEMINIST MODEL OF PND**

Although there are psychological, interpersonal and sociocultural perspectives on postnatal depression, the medical model is the dominant one in terms of academic, professional and lay understandings of postnatal depression (Mauthner, 1999). The feminist approach, by contrast, has evolved largely as a critique of the medical model and is grounded in a more qualitative tradition. It emphasises women's experience of postnatal depression as a normal response to motherhood. It is argued that the medical model provides only a limited understanding of postnatal depression. In order to achieve a fuller picture one has to take into account the broader social, political, economic and structural contexts and the ways in which they interact with individual women's circumstances to render them "depressed" following childbirth.

In this chapter I will present and discuss the limitations of the medical model and the feminist alternative to this perspective. In order to do this it will be necessary to outline the theoretical foundations on which the medical model is based i.e., the empirical model of investigation into psychological research. At the same time the feminist perspective will be presented as a preferred alternative method of research.

#### **METATHEORETICAL ISSUES**

Empirical research has its roots in positivism – a social theory expounded by Auguste Comte (1816) and Emile Durkheim (1938). The emphasis is on searching for the facts and causes of human behaviour through objective, observable and quantifiable data. The research subjects are seen as passive/reactive organisms – metaphors of basic matter in the "hard" sciences and the researcher is viewed as an objective scientist. Every effort is made to minimise any relationship between the researcher and the research subject through fear of influencing or contaminating the findings (Alexander, 1982; Gergen, 1988). The rationale behind this insider/outsider perspective is to allow the researcher to investigate "facts" which are free from the potential biases of private intuition and which may vary from one person to another (Stainback & Stainback, 1984). Feminist writers have criticised this view for its limitations and

androcentricism (Chodrow, 1978; Harding, 1986). They argue, for example, that this pattern of separateness of scientist from subject is a mere reflection of the male psyche where personal identity is established through separation and differentiation from their mothering agents (Chodrow, 1978). The irony of the traditional argument is that it is impossible for two people to have “objective” contact with one another in the process of scientific research (or in any other situation). The alternative is to base scientific methods of inquiry on the acknowledgement of interconnectedness between people. A feminist metatheory and methodology would thus incorporate the tenet that the investigator and the subject are interdependent (Gergen, 1988).

The empirical-analytic paradigm also attempts to separate itself entirely from the moral terrain by maintaining an air of objectivity and scientific rigour in its pursuit of factual knowledge. This is achieved through the use of quantitative methods of research where people’s thoughts and feelings are typically expressed in numerical notations which, in turn, are expressed as brute facts which exist outside and independent of the people (Stainback & Stainback, 1984). The “facts” are also assumed to be independent of the scientist who establishes them and become lawlike orders which are seemingly value-free. The constitution of these facts is concealed which “thereby prevents consciousness of the interlocking of knowledge with interests from the life-world.” (Habermas, 1972, pp. 305/6). The assumption that knowledge and its creation can be value-free is refuted by feminist scholars who insist that work should rather be value-laden thereby redefining personal qualities that have been made negative through male-dominated theorising (Gergen, 1988). Furthermore, the feminist position argues that scientific inquiry requires acts of interpretation which, in the first place will produce more “real”, “rich”, and “deep” data (i.e., more meaningful) and, secondly, will contribute to the creation of a relevant vocabulary and theoretical framework where established facts are not “reflective of the world as it is, but the world as subjected to an a priori linguistic framework” (Gergen, 1988, p. 92). Issues of language are of importance to the feminist position not least of which is the use of androcentric metaphors in scientific work. For example, Bart (1971, cited in Gergen, 1988) questions the use of adjectives such as “hard” and “soft” in the sciences (e.g., hard facts/ soft facts) and has since substituted this male metaphor with one based on the female sexual experience, referring to “wet” and “dry” data. The situation remains, however, that certain metaphors have become so compelling and

standard in their use that very little attention has been given to alternative expressions and perspectives (Gergen, 1994).

In order to establish general laws of human functioning the empirical psychologist identifies and tests relationships among isolated variables thereby decontextualising phenomena from their cultural and historical backgrounds. Such a particularistic focus is achieved through the use of standardised tests, questionnaires etc. which allow for structure and control of the study but conceal any variability in individual responses and deny holistic perspectives on whatever is being investigated. Reality is portrayed as stable and unchanging. For example, women suffering from postnatal depression are often studied in isolation from their personal circumstances resulting in the depression being attributed to biological causes or individual personality factors rather than to difficult social conditions which may stem from their position as an oppressed group. Every attempt should thus be made to conduct research without violating the social embeddedness of the subject so that a total or as complete as possible picture is sought and portrayed.

Implicit in the scientific pursuit of knowledge is the superiority of "Science" and "the Scientist" over the subject. This is manifested in a variety of methodological practices in which the researcher expects to have complete control over the way in which the study proceeds, subjugating and exploiting the subject who is presumed to be less knowledgeable and less competent than the researcher (Olesen, 1994). Gergen (1988) argues that such scientific dominance echoes the traditional patterns of gender relationships and sexual dominance in the culture. As an alternative, feminists argue for the "enhanced voice of research participants" (Gergen, 1988, p. 94). Scientists should see themselves as participants in the research project and should respect and make use of the views and perspectives of the subjects and their experiences so that the research itself is a process which is open to flexibility and change. This would also serve to break down the power differentials that exist between the researcher and the researched in the research process. In such a qualitative paradigm research is oriented towards discovery of new theories and hypotheses as data is collected rather than verification of predetermined hypotheses typical of the positivistic paradigm. Accordingly, a deeper and more valid understanding can be achieved than with a more controlled and restricted approach.

Gergen (1988) summarises the limitations of traditional empirical methodological principles as follows:

1. The independence of scientist and subject;
2. The decontextualization of the subject matter from the field in which it is embedded, physically and historically;
3. Value-neutral theory and practice;
4. The independence of “facts” from the scientist;
5. The superiority of the scientist over other people.

Growth and development in feminist theory has evolved rapidly but the implications of these theories and metatheories for methodology have not been spelled out as adequately. For example, some scholars who align themselves with feminist theory in the social sciences continue to practice within a traditional methodological framework (Gergen, 1988). The values of quantitative methodology for feminist research are expounded by Jayaratne (1983) who argues that although data derived from traditional processes are analysed as numerical values, it is still the *meaning* of the numbers which determines how the analysis proceeds and is the basis for interpretation of results. She continues to justify quantitative methods by saying that the use of objective and statistically significant findings derived from the qualitative paradigm are effective tools in influencing (male) policy-makers on matters relevant to the feminist position. Furthermore, it is argued by both Jayaratne (1983) and Gergen (1988) that while new feminist theories may be allowed into a discipline, methods that deviate from the old ones or that challenge traditional assumptions are generally not published. Nevertheless, what is called for is the development of new methods which support the feminist metatheories and which have credibility in the social scientific world.



## THE MEDICAL MODEL OF POSTNATAL DEPRESSION

The medical model of postnatal depression is characterised by quantitative, positivist studies which explore postnatal depression in terms of hormonal and biological factors, hereditary factors and the personal and familial history of women. According to this paradigm, postnatal depression is construed as a medical entity: it is pathologised as an illness (e.g., postnatal depression is a *syndrome of severe postpartum illness* (Hamilton, 1989, p. 92)); and it is understood and explained within a medical framework using technical terms such as “syndrome” and “symptoms” (e.g., “... what constellation of *symptoms* determine postnatal *syndromes* (Hopkins, Campbell & Marcus, 1989, p. 252)). Two observations stand out when reviewing the above studies that characterise the medical model:

- a) They are fundamentally based on the traditional objective, empirical approach to research, typical of the positivistic paradigm and
- b) Despite the fact that depression following childbirth is exclusive to women, most of these studies are conducted by men and the research findings and theoretical perspectives underpinning knowledge of this problem reflect male values (Nicolson, 1986).

While the endocrinological explanation of postnatal depression may play an important role, it is essentially reductionistic in its approach in that it ignores highly complex social and psychological factors that interact with the physical in affecting mother's moods. Feminist sociologists and psychologists such as Oakley (1980), Nicolson (1986) and Romito (1990) have criticised the medical model of postnatal depression. This argument will now be presented as an alternative to the medical model.

## A FEMINIST APPROACH TO POSTNATAL DEPRESSION

The feminist model of “postnatal depression” stands in stark contrast to the medical paradigm and is based on several basic criticisms of the medical model. Firstly, the medical model classifies postnatal depression as a “disease” or “illness” that exists as an objective, clinical entity. This label has become an accepted “fact” of female life

and creates a false dichotomy between a “normal” state of mental health and a supposedly “pathological” one where “normal” motherhood is by definition a happy and “depression-free” experience (Mauthner, 1993). Oakley (1979) argues that postnatal depression is not a scientific term but an ideological one which mystifies the real social and medical factors which lead to mothers’ unhappiness after childbirth. The use of this label, according to Nicolson (1986), has enabled men to account for women’s behaviour without having to understand its complexities which are embedded in the social nature of women’s problems. The important point here is that there are understandable reasons why motherhood may be problematic and, in fact, perhaps the normal reaction to motherhood lies more at the unhappy end of the continuum than at the happy end. Male-dominated research on postnatal depression apparently dismisses the idea that having a newborn baby to care for, as well as the usual duties of looking after older children and one’s partner and performing most of the domestic chores while still recovering from the physically draining experience of childbirth, lactation and sleepless nights is simply too heavy a load to carry for many people. Is such a response to childbirth a deviation from the norm or merely a reflection of how the average person (male or female) would cope in a similar situation? The biochemical changes that occur during pregnancy, childbirth and the postnatal period must feature in any comprehensive understanding of postnatal depression but not to the exclusion of other important social factors. Postnatal depression is not just a medical problem but also a social one (Mauthner, 1993).

Feminists have also taken exception to the deterministic notion of the aetiology of postnatal depression in the medical model which depicts postnatal depression as a unitary phenomenon i.e., a product of hormone imbalances or personality characteristics or individual stressors alone (Nicolson, 1986). Research designs within the medical paradigm rely almost exclusively on standardised measures and “objective” data which has two serious consequences relevant to the feminist argument. In the first place, such research designs render individual differences non-existent – no recognition is made of differences between mothers, nor of the fact that the same event (e.g., a difficult birth experience) may have a different meaning to different women depending on their individual circumstances and expectations. Secondly, they include perspectives which place women in the category of “faulty machines” whether on a physiological or psychological level (Nicolson, 1986). That

is, determinism in this context means that mothers are portrayed as passive recipients who do not actively interpret and make sense of the events and circumstances surrounding them (Mauthner, 1993; Nicolson, 1986). The limitations of determinism conceal the myriad of factors which should be considered when investigating the aetiology of postnatal depression.

A third criticism of the medical approach to postnatal depression is that it locates the source of the problem and thereby the blame exclusively within the individual mother, or her particular circumstances. While some empirical studies investigate the role of certain social factors which may interact with biological factors in rendering women more susceptible to postnatal depression (Romito, 1990), their theories nonetheless fail to go beyond the level of the individual to address the wider sociopolitical and ideological context and structures in which mothers' experiences are embedded (Mauthner, 1993). Implicit in these theories is the androcentrism of the concepts employed (again Nicolson's (1986) metaphor of women as "faulty machines" comes to mind) and more explicitly, the risk of "victim-blaming" they pose when employed in the treatment of depression which will be predominantly intrapersonal, while the status quo of the reality of women's lives will remain unchanged (Mauthner, 1993; Stoppard, 1998). To blame the individual mother for postnatal depression is thus inappropriate and short-sighted in that it fails to see their actions within the broader cultural context (Gergen, 1999; Mauthner, 1998a).

Perhaps the most vehement criticism of the medical model from a feminist perspective is its failure to listen to women's voices. There is a disregard for women's expressions of their feelings, their experiences and their knowledge. No attempt is made to understand women in their own terms and on their own terms because traditionally researchers have been preoccupied with their own interests, that is discovering what is the "objective" "truth" about the issue (Nicolson, 1986). The methodological limitations of the medical model (e.g., the use of standardised measuring instruments in the pursuit of "objective" knowledge), has not only silenced women's interpretations of their experience of postnatal depression but has also resulted in a limited framework for understanding the aetiology, course and treatment of the disorder. Furthermore, women in the throes of postnatal depression may feel apprehensive about talking about their distress for fear of being labelled "sick" or

being misunderstood by a population of clinicians who have only been informed by quantitative research publications which suffer from all the shortcomings of the medical model listed above.

This raises Danziger's (1985) problem of the methodological imperative in psychology. He argues that traditional psychological methods contain theoretical assumptions about the empirical world that they are investigating. Thus, research that uses traditional methods (e.g., statistical analysis) produces data that can only confirm their assumptions – this results in a methodological circle where methodology, which is theory-laden, produces facts which support these isomorphic theories (theories which contain these methodological assumptions) which, in turn, continue to inform methodologies. Thus, few studies report any qualitative data even by way of illustration and even those studies which do describe the experiences of depressed mothers (Breen, 1975; Oakley, 1980) are seldom quoted in the research on postnatal depression because research in this field has become fixated in the methodological circle of the traditional medical model which may be rendered contradictory or invalid or even inconsistent if “contaminated” by qualitative findings. Methods, Danziger (1985) argues, are merely tools and should not restrict the kinds of knowledge that can be generated. Romito (1990) supports this position by stating that the wide variation in the occurrence of postnatal depression reported in separate studies suggests that the phenomenon labelled “postnatal depression”, “rather than being a natural entity, is defined and actually constructed by the very instruments used to measure it, and in more general terms, by the very process of research” (p. 8).

A feminist understanding of postnatal depression thus criticises the medical model for the following reasons:

1. Postnatal depression is not just a medical problem but also a social one
2. The limitations of determinism
3. Blaming the individual mother
4. Failing to listen to women's voices

What seems to be required is the development of a feminist methodology and a woman-centred perspective on women as “new” mothers. The difference between traditional methodology and this enlightened feminist position lies in the researchers’ conceptualisation of the problem (e.g., conceptualising unhappiness after childbirth in a different way to the medical model; namely, as an appropriate response to the difficulties encountered by mothers as a consequence of their social, psychological and ideological position in society); relationship with the respondents (e.g., taking into account the intersubjectivity and commonly created meanings between researcher and participants); and the collection, analysis and dissemination of the data (e.g., recognising the importance of research for women and using it to formulate policies necessary for feminist activities) (Nicolson, 1986). To conduct research in this way may be more difficult and demanding than traditional techniques in that it takes more time, it poses problems of variability in data and requires an intimate understanding of the lives of others. However, the benefits of the process and outcome of this type of research is undoubtedly more meaningful, accurate (in terms of its reflections of reality which is not always as coherent as we would like it to be), and beneficial to the social sciences and the population at large.

## **THIS RESEARCH PROJECT**

Despite a plethora of investigations into the causes of postnatal depression, little attention has been paid to the insights of women who have recovered from postnatal depression and their lay theories of why they think they experienced postnatal depression. McIntosh (1993) addressed this problem in a study he conducted on 38 women who were in the throes of postnatal depression. He found that the single most popular reason given by mothers for their depression was the difficulties associated with the experience of motherhood itself such as the never-ending demands of infant care; the restrictions, loss of freedom and responsibility involved; loneliness and isolation; absence of support and lack of time for oneself. Other factors raised by McIntosh (1993) related to housing problems, unemployment, financial pressure, problems with one’s partner/husband and hormonal fluctuations.

In another qualitative study on postnatal depression, Mauthner (1998a) interviewed 18 women with the aim of understanding their experience of postnatal depression. She found that the most common explanation given by the women for their postnatal depression related in some way to the conflict they experienced between their expectations of motherhood and their experience of themselves as mothers. These conflicts revolved around three main issues: firstly, the expectation to bond immediately with their babies which, in reality, they did not experience; secondly, the expectation that they would be happy with their new baby when, in fact, they were not; and thirdly, the expectation that they would be able to cope single-handedly with their new child on both a practical and emotional level which proved not to be the case. In sum, women felt a split between what Breen (1975) refers to as “a very idealised picture of what they felt a mother should be like ... and the way in which they saw themselves after the birth of the baby” (p. 192).

No study has specifically looked at survivors of postnatal depression and their explanations of why they experienced postnatal depression. It is thought that women, having recovered from postnatal depression and thus with the advantage of hindsight, would have processed their experience and made sense of it in particular ways which would highlight their insights into this problem.

This study thus has two aims: In the first place, it aims to explore women’s accounts of their understanding of the causes of postnatal depression. It thus follows in the tradition of feminist research which seeks to listen to women and understand their lives in and on their own terms. The qualitative nature of this research addresses the limitations of existing models of postnatal depression, which are grounded in the positivist tradition of objective, value-free research of a quantitative nature.

In addition to exploring a women-centred perspective on the causes of postnatal depression, this study has a second aim – that of examining the extent to which women’s aetiological explanations of postnatal depression resonate with existing perspectives currently in the literature.

## **CHAPTER FOUR**

### **METHODOLOGY**

#### **PARTICIPANTS**

The participants in the study were women who have recovered from postnatal depression. The experience of motherhood and postnatal depression can be particularly overwhelming for some women and their ability to make sense of the experience may be clouded by the demands and exhaustion associated with a new baby (Lewis & Nicolson, 1998). Hence it was thought that by conducting a retrospective study the women would be able to identify and explain the causes of their postnatal depression with greater insight and perspective than while in the throes of their experience.

#### **Sampling**

The design of the study was not conducive to systematic sampling in the traditional sense, as it was not intended to make statistical generalisations or predictions from the data. The aim, as in a number of recent qualitative investigations into postnatal depression (Beck, 1993; Mauthner, 1998a, 1998b, 1999; Nicolson, 1999), was to see how a small cohort of women understood their experience of postnatal depression and, in particular in this case, the causes of their postnatal depression.

The sample was obtained from a number of sources. The initial recruitment was from The Postnatal Depression Support Association (PNDSA) – a national organisation in South Africa which provides information and support for women suffering from postnatal depression. In addition to this, recruitment took the form of “word of mouth” and “snowballing” in that some of the early participants recommended friends, who in turn did the same (Nicolson, 1999).

It is clear that this method of selection would produce a skewed sample of women in that they all would have attended the PNDSA support groups or would have had connections with other women who had been through the groups. They thus would have been exposed to insights and information about postnatal depression from the

facilitators and other members of the groups. However, it is thought that having recovered from postnatal depression and not having been in the support groups for some time they would have processed their experience in a uniquely individual way in order to make sense of it. It is this individual perspective gained from hindsight that will be explored in this study.

The sample eventually comprised 20 women whose ages ranged from 30-45 years with an average age of 36 years. They were all married except for one, and 16 of the women had postnatal depression with their first child, while 4 had it with their second child. For the purposes of this study the women were required to focus on and speak only about that principle child i.e., the child after whose birth they got postnatal depression. Of the principle children in the study 15 were from planned and 5 were from unplanned pregnancies. Mothers of unplanned children who suffer from postnatal depression have the added difficulty of having to deal with the guilt either of not having wanted the child or of having felt initial disappointment when the pregnancy was confirmed (Kleiman & Raskin, 1994). Whether the child was a first or second-born or whether the child was planned or unplanned, it was hoped that the women in this study would raise the relevance of these issues to their postnatal experience during the course of our discussion on the causes of postnatal depression.

In order to assess whether the women had indeed recovered from their postnatal depression the Edinburgh Post Natal Depression scale was administered. The cut off point for this scale is 13 points and all of the women in this study scored either 13 or below on the scale. This indicated that the women had largely recovered from their experience of postnatal depression.

This sample had a relatively high level of education with 12 women having a postgraduate degree, 3 having a university degree, 4 having a tertiary degree and one having a matriculation. Although the purpose of this study is not to make generalisations, it should be noted that this relatively high level of education be taken into account when considering perceptions of postnatal depression in less educated populations.



## DATA COLLECTION

Data was collected through individual, in-depth, interviews which took the form of a planned discussion rather than a structured interview. The discussion covered a number of areas including the women's experience of postnatal depression, their thoughts on why they think they got postnatal depression and various other relevant questions (see Appendix 1).

Initially the option of focus groups was investigated but this idea was rejected for the following reasons: focus groups tend to yield more breadth than depth of information and elucidate shared understandings that come from group interactions rather than unique individual perceptions (Crabtree, Yanoshik, Miller & O'Connor, 1993). For this study it was thought that individual and in-depth investigations into women's perceptions would be more valuable bearing in mind that the goal of the study is to highlight idiosyncratic explanations of the aetiology of postnatal depression from women who have survived this experience.

In addition to the in-depth interviews the Edinburgh Postnatal Depression Scale (Cox et al., 1987) was administered. This is a 10-item self report scale which has been found to have satisfactory sensitivity and specificity, both in its original validation and in a more recent study involving a larger community sample (Lussier, David, Saucier & Borgeat, 1996; Murray & Carothers, 1990). This scale was administered in order to confirm that women taking part in the study no longer suffer from postnatal depression. (see Appendix 2).

Venues for the interviews were dictated by what was most convenient for the participant, particularly in terms of time and transportation constraints. Most of the interviews took place in the researcher's home while others took place in the participants' home or place of work. A relaxed and undisturbed environment was created in all interviews.

Participants were thanked for taking part in the study and were told what to expect from the interview session. They were assured of confidentiality and were asked permission for the interviews to be tape-recorded and then transcribed by the

researcher and a professional transcriber. Informed consent was received from all the women and they were told that they could terminate the interview at any stage or could choose not to answer any questions that they did not feel comfortable to talk about.

The interviews took, on average, one and three-quarter hours with the longest interview taking 3 hours.

## **DATA ANALYSIS**

The in-depth discussions constituted the data for this research project. The following section will elucidate the methods of analysis used for this set of data.

### **Transcriptions**

All of the in-depth interviews were recorded on audiocassette. The interviews were then transcribed verbatim. Every transcript was checked to ensure that the cassettes were accurately transcribed and these interview transcripts then became the source of data. The transcripts of the interviews are available for perusal from the researcher.

### **Methods**

The analysis of the data was informed by two main bodies of qualitative research analysis: Grounded theory and Content analysis.

Grounded theory was developed by sociologists Glaser and Strauss (1967) and became popular with social scientists who were trying to overcome the limitations of research which analysed qualitative phenomena in quantitative ways (Keddy, Sims & Stern, 1996). The aim of grounded theory is to generate theory which is fully grounded in the data. As Charmaz (1990) states, the “groundedness” results from the researcher’s commitment to analyse what they actually observe in their data – unexpected themes may emerge and must be pursued. A basic tenant of grounded

theory is thus to go into an area of research without preconceived hypotheses – the research process requires openness and flexibility as it does not pivot on a priori assumptions of what may and may not be found (Henwood & Pidgeon, 1995).

Theoretically the concept of going into the data without preconceived ideas is rather idealistic. In reality and practice, analysis of the data starts before the data are collected in that the parameters are set by the questions and the categories selected in the construction of the interview (Nicolson, 1999). Nevertheless, every attempt was made to engage with the data with as open a mind as possible and a willingness to approach the data with a fresh outlook should new or different material emerge.

In accordance with current feminist methodological approaches, Grounded theory allows for the voices of participants to be heard as well as multiple explanations of reality (Keddy, Sims & Stern, 1996; Wuest, 1995). From a practical point of view it requires the researcher to engage in a constant comparative method wherein each line, phrase, sentence, and paragraph of transcribed data are reviewed to decide what concepts the data reflected and to code the data accordingly. Each code is then compared to all other codes looking for similarities, differences and general patterns (Beck, 1993). At all times the researcher has to:

- a) attend closely to the data (which may elicit new discoveries)
- b) build theoretical analyses directly on the interpretation of processes within the data
- c) compare their analyses with the existing literature and theory (Charmaz, 1990).

As mentioned previously, the aim of this research project was twofold: Firstly, to arrive at an understanding of how women themselves understand the causes of their postnatal depression and secondly, to examine the extent to which these lay explanations resonate with existing aetiological models of postnatal depression. It was therefore unnecessary to engage in a theory-building process as required by a traditional Grounded theory approach. Rather, the basic tenet of grounded theory analysis (i.e., to analyse the data using the constant comparative method) informed the process of content analysis in this study.

Thematic Content Analysis, in its broad sense, also involves restructuring communications in order to make sense of them (Mostyn, 1985). To gain insight into the meaning of the data, the researcher takes the raw material and scrutinises it for regularities in themes or concepts which can be brought together in a way that makes sense of the data. In practical terms Mostyn (1985) lists the following procedures:

1. Immersing oneself in the data: Read it over and over again
2. Categorising the data: Select categories with which to organise the analysis
3. Incubation: Set the research aside for a number of days in order to let the various ideas jell in the researcher's mind
4. Synthesis: Read through the data to look for new patterns, relationships or key concepts
5. Interpretation: To make sense of the data and create meaningful insights and perspectives from the data.

### **Codes and Categories**

The formation of codes and categories in the process of analysing the data involved a number of stages. While checking each transcript for its accuracy the broad categories that were emerging from the data were noted. All the transcripts were then read and re-read in order to become thoroughly familiar with the full picture of the data. The ground was now prepared for creating categories which involved extracting from the immense detail and complexity of the data those features which were most salient to the purposes of this study i.e., why the participants thought they had suffered from postnatal depression (Dey, 1993). A set of categories was built up to which one or more instances or quotes in the data could be referenced (Henwood & Pidgeon, 1993). Each category was coded in the margin of the transcript next to the relevant text.

Using the cut and paste facility on the computer, all relevant quotes pertaining to each code were systematically collected. In total, 62 categories of data were created. This first list of categories was very specific and detailed and many of the categories were not mutually exclusive and could be combined under a broader theme. The categories

were thus consolidated into a core structure of 13 more general themes (see Appendix 3).

Again, all relevant data was grouped together under these 13 themes. As Mostyn (1985) recommends, the project was then set aside for several days in order to allow for all the information to “sink in”. The data was then examined again for key concepts, common themes and potential emerging patterns. At this point difficulty was encountered in incorporating all the data into a coherent picture. Mostyn (1985) suggests that the researcher engage in a culling process in order to deal with this problem: “Original hypotheses that cannot be supported will have been abandoned; fresh ideas that seemed to emerge out of the data during a first read-through may not have been sustained...confusing and contradictory ideas ... have to be abandoned... The objective is to produce a clear communication of what happened without too many qualifications” (p. 139).

The crucial stage of the analysis involved interpretation. That is, working out the meaning of the data – what is really being said by the participants. This requires the researcher to stand back from the data and gain perspective; to work through contradictions and explore new relationships – to “give one’s imagination and creative powers free rein; and allow intuition a chance to come to fruition” (Mostyn, 1985, pp. 140-1).

The data analysis process outlined above enabled 13 categories and themes to be identified. These major themes are discussed in the next chapter.

## CHAPTER FIVE

### RESULTS AND DISCUSSION

This chapter will discuss the causes of postnatal depression as expressed by the women in this study. In order to create some structure to the analysis of the themes derived from the data, I have grouped the various themes under four general headings which could be identified from the women's perceptions. The first heading – Interpersonal factors – includes those attributions which relate to the women's relationships with their partners, their mothers and their broader social support system. The second heading – Psychological factors – comprises those causes which are intrapsychic in nature, such as unresolved trauma, loss and personality factors. Included under this heading is also the category labelled “stressors” because it relates to the diathesis-stress model of depression which is generally assumed to be one of the many psychological theories of depression. The third heading – Motherhood – includes those explanations of postnatal depression which are directly related to being a mother, be it pregnancy, childbirth, mothering issues, sleep issues and issues around work. Finally, Biological Factors comprise those attributions which the women believed predisposed them to postnatal depression on a physical level such as biochemical imbalances, hereditary factors or a previous history of depression in themselves or a member of their immediate family.

All of the women referred to a number of causes for their postnatal depression. In other words, the aetiological picture, for them, was multifaceted and did not fit into a single neat category. A summary of the respondents' perceptions of the causes of postnatal depression can be found in Appendix 4.

## **SUMMARY OF HEADINGS AND THEMES**

### **1. Interpersonal factors**

- a. lack of support
- b. relationship with partner
- c. relationship with own mother

### **2. Psychological factors**

- a. unresolved trauma
- b. loss
- c. personality factors
- d. stressors

### **3. Motherhood**

- a. pregnancy
- b. birth experience
- c. mothering issues
- d. sleep issues
- e. work issues

### **4. Biological factors**

- a. predisposition

## INTERPERSONAL FACTORS

### Lack of Support

Half of the women in the sample (10) attributed the cause of their postnatal depression to lack of support, in particular from their partners. The women referred to a lack of emotional support and/or practical support. According to them, practical support refers to domestic help either from family members or hired help, as well as assistance in taking care of the baby's physical needs e.g., nappy changes, bathing and so on. Emotional support, on the other hand, refers to significant others giving the mother encouragement, acknowledgement of her efforts, listening to her in a non-judgemental way and allowing her to express her thoughts and feelings, be they positive or negative, in an atmosphere of love and acceptance.

Vanessa\*, for example, felt unsupported on an emotional level and regards this as the primary reason for her postnatal depression:

**I was having to give emotional support to the baby but nobody was giving it to me – and.... I, I, I don't remember much more than that it felt unbearable.**

She continues to refer to her mother and her husband:

**I had some concerns about how both of them were going to be able to get me... the support that I needed... and ... it, I felt, I, I think the reason it (the PND) happened at six months was that.... At that point I realised that they weren't, either of them, going to be there for me in the way I'd hoped.**

\* all respondents names are fictitious so as to protect their confidentiality  
(see appendix 5)



While Vanessa was attending to her baby's emotional needs (be it that her baby needed to be soothed when crying, rocked to sleep or held securely during a vulnerable moment), she felt that no-one was nurturing her emotional needs which were perhaps not dissimilar to her baby's. Her mother and her husband were available and present in her home to give her support but she expresses her disappointment about them not being able to give her what she needed. On a practical level they did prepare meals, wash dishes or change nappies but what was lacking for Vanessa was attention to her emotional well-being. This, she believes, is what triggered her postnatal depression – the realisation that her husband and her mother were unable to meet her expectations as far as emotional support was concerned.

This raises the distinction between “available” support and “enacted” support. While Vanessa's mother and husband were available to give her support, the actual (enacted) support received from them was inadequate. Lack of enacted support in the face of available support may be more difficult to bear than lack of enacted support where no support is available. In other words, when support is available one may have the expectation of being supported following the birth of a child but where it is not available, one expects oneself to carry the load of childrearing alone.

Different types of support are needed at different times following the birth of a child. For example, Seguin, Potvin, St-Denis & Loiselle (1999) found that a lack of informational support in the early postpartum period was linked to depressive symptoms at the third week postpartum. In the long term, however, emotional support was most significant in protecting against later depressive symptoms. Indeed, emotional support provided by the husband and others has repeatedly been found to be inversely related to postnatal depression (Chung & Yue, 1999; Gjerdingen, Froberg & Fontaine, 1991; Mills, Finchilescu & Lea, 1995; Misri, Kostaras, Fox & Kostaras, 2000; Nicolson, 1990; O'Hara, 1986; Richman et al., 1991; Spangenberg & Pieters, 1991; Wandersman, Wandersman & Kahn, 1980).

Unmet expectations with regard to postnatal support seems to be the key factor as far as postnatal depression is concerned (Logsdon & McBride, 1989; Rankin, Campbell & Soeken, 1985). More specifically, it is when pregnant women have the expectation of support following the birth of the baby and that is not met that postnatal depression

is more likely to occur. Logsdon et al. (1994) explain this by saying, “the unexpected appears to be unsettling, and may lead to feelings of loss of control” (p. 455) which, in turn, may lead to depression (Franks & Faux, 1990). This supports Vanessa’s perception that it was the disappointment in her significant available support that thrust her into her depression. Richman et al. (1991) note that there is a relative lack of adequate interpersonal support following the birth of a child in Western societies when compared to that of traditional indigenous cultures. Support in the latter involves mandated rest, instrumental help, and social recognition through rituals and gifts marking the new status of mother (Cox, 1988; Harkness, 1988; Stern & Kruckman, 1983). Furthermore, in the absence of extended family support structures, mothers often feel isolated and lonely in the postpartum period (this feeling of isolation will be discussed later).

Apart from emotional support, practical or instrumental support is just as important for new mothers to cope with postpartum stress. Sharon felt that she would not have suffered from postnatal depression had she had some form of practical domestic assistance:

**It was a case of just feeling like I had so little support... the mornings were just too terrible where she (baby) would have needs and he (older sibling) would be playing up and I would be trying to get out of the house, get him to school...um...just trying to leave the house in the morning, get the washing in the machine and out the machine and on the line...there was no one else to do it.**

Maintaining a family and a home on a domestic level not only involves hard work but that work is also tedious, repetitive and, for the most part, unfulfilling. Sharon was desperate to escape from her domestic commitments – to get out of the house – but felt unable to do so because there was no-one else to take over from her. Furthermore, the urgency for her to complete the washing, for example, before she left the house is not necessarily an uncalled for pressure that she is placing on herself – as a mother without domestic support she spoke about the fact that no-one else was going to get the job done for her. Hence, she had to anticipate what the day ahead held for her and

that perhaps that was the only stretch of time for the washing to dry while she attended to other chores such as taking care of her baby, taking her son to school, shopping, cooking and so on. To manage a home and children takes careful planning and to do so alone can be depressing for many women.

Indeed, as far as instrumental support is concerned, its negative impact on postnatal depression has been well documented (Chung & Yue, 1999; Romito, 1990; Small, Astbury, Brown & Lumley, 1994; Teti, O'Connell & Reiner, 1996). Paykel et al. (1980) found that help with household chores, shopping and caring for other children had an ameliorating effect on postnatal depression. Levitt, Weber & Clark (1986) also found that practical childcare support was inversely related to psychological well-being among adult mothers. Other studies, however, have shown that the more instrumental support mothers received, the higher the levels of depressive symptomatology (Hackel & Ruble, 1992; Leathers, Kelley & Richman, 1997). Leathers et al. (1997) explain the latter finding by highlighting the fact that women experiencing postnatal depression may elicit more help from others who are aware of their distress. Thus, rather than lack of support being seen as a cause of postnatal depression, Leathers et al. (1997) argue that when women have postnatal depression they recruit more support for themselves because they are unable to cope on their own. Hence, the amount of support received was not related to causality of postnatal depression but rather was related to effect i.e., because they were depressed they received extra help.

Mauthner (1998c) found that in her qualitative study of 18 women suffering from postnatal depression, "the limited involvement that many of the male partners had in childcare and housework ... was linked, in some cases, to the women's depression" (p. 387). This, she continues to argue, "is a cultural issue in the sense that society holds different expectations of men and women in which men's limited lack of involvement in the home is acceptable and to some extent expected, while women are expected to carry out most, if not all, of the childcare and housework" (p. 388).

Some of the women felt that their partners simply did not know how to give the practical and emotional support they needed. As Elaine says:

**My baby's father wasn't very supportive. You know, not emotionally supportive anyway. He didn't know how to be.**

While this incapacity may be true in some cases, the possibility that some mothers facilitate their partner's incompetence may also be true. As Mauthner (1998a) says of her study "partners *would* have been more involved, were it not for the fact that they themselves (the mothers) tended to discourage their partners' involvement, either because they had "different standards" for housework and childcare, and/or because they preferred that their partners spend their time at home either with them, or with the children, rather than doing housework" (p. 164). By imposing their own standards and methods of childcare and housework on their partners, women are essentially facilitating their partner's incompetence. In other words, if the men were left to manage either their child or the house on their own, they would work out ways of coping and handling different situations. When men are left with lists of ways to look after the baby or the house they are denied the opportunity to be creative in these tasks and thereby feel disempowered by their apparent inability to manage whatever they are faced with in terms of the baby or the house. Hence women land up alienating their partners by disempowering them and not entrusting them with what should be a more than manageable job.

By disempowering men when it comes to childcare, some men may feel that the only way they are able to help is by doing the housework. As Vanessa says about her husband:

**He would rather wash the dishes than help with the baby, and I would say, "I need help with the baby" and he'd say "I have helped you with the baby, I've just washed the dishes" and I'd say "that's not what I mean, I mean I need a break from being with the baby. I would *love* to wash the dishes".**

Mauthner (1998a) goes on to say that perhaps it is because of the mother's withdrawal from her partner that she didn't receive the support that she wanted rather than the partner being unavailable to provide that support. Furthermore, while some women

are able to communicate their needs, others, like Jessie in the present study, remain silent for fear of being perceived as incompetent in their role as mother:

***I really didn't have any support, and I didn't know if I should say anything to anybody because ... maybe they would think that I was selfish, maybe they would think that I wasn't a good mother, a natural mother, or whatever.***

What is a “good mother” or “natural mother”? Do “good and natural mothers” neglect their own “selfish” needs in order to take care of their children? Do good and natural mothers cope single-handedly and without complaint? The fundamental question that arises here is what does Jessie expect of herself and, more importantly, what is feeding those expectations? This issue will be addressed time and again in this chapter as it stands out as an underlying theme in most of the categories raised by the respondents.

Such concerns are not uncommon for mothers. Mauthner (1998a), similarly, found that women were reluctant to ask for practical or emotional support because “they feared burdening their partners or being misunderstood” (p. 165). She goes on to say that the mothers in her study resisted seeking support during their depression because of “moral constraints on seeking help based on their “moral beliefs” that: mothers should not feel depressed or ambivalent about motherhood; mothers should not need practical or emotional support; and mothers should not express their feelings and needs” (p. 165).

The transition to parenthood for both mothers and fathers is challenging at best and extremely stressful at worst. New and unexpected demands are not only experienced by the mother but also by the father (Mathhey, Barnett, Ungerer & Waters, 2000; Meighan, Davis, Thomas & Droppleman, 1999; Soliday, McCluskey-Fawcett & O'Brien, 1999). While some studies have shown that men are more dependent on their spouse for both emotional and practical support, women tend to seek out such support from more diverse network sources (Antonucci & Akiyama, 1987; Richman et al., 1991; Tarkka, Paunonen & Laippala, 1999). However, in this study, as in others (Grace, 1993; Misri et al., 2000; Power & Parke, 1984; Priel & Besser, 2000; Terry,

Mayocchi & Hynes, 1996; Wandersman & Wandersman, 1980), it became evident that women rely heavily on their partner's support in negotiating this life changing event. This, at a time when her partner may also be overwhelmed by the experience, may place additional strain on the marital, as will be discussed later in the next section.

### **Relationship with Partner**

In the present study, nine out of the twenty women attributed their postnatal depression to the discord in their relationship with their partners. Nora Ephron has described the birth of a first baby as a hand grenade thrown into a marriage (cited in Maushart, 1997). Maushart (1997), similarly, says, "having children, we imagine (not unreasonably) will enrich our partnership. Yet, the reality is that parenthood will almost certainly erode the terms of that partnership irrevocably" (p. 277). That the marital relationship experiences a deterioration over the transition to parenthood is a finding repeatedly confirmed in research (Belsky, Spanier & Rovine, 1983; Culp & Beach, 1998; Dimitrovsky et al., 1987; Gotlib et al., 1991; Kumar & Robson, 1984; McGill, Burrows, Holland, Langer & Sweet, 1995; Miller & Sollie, 1980; Misri et al., 2000; O'Hara et al., 1990; Robinson et al., 1989; Seguin et al., 1999). What is not always clear, however, is whether a bad relationship renders one vulnerable to postnatal depression or the reverse. Research into the relationship between marital quality and depression in general has produced conflicting results. Although some research suggests that depression precipitates marital discord (Beach & O'Leary, 1993; Robinson et al., 1989) there has been support for the converse argument that marital discord often precedes and plays a causal role in depression (Brown, Andrews, Harris, Adler & Bridge, 1986).

Fiona, in the present study, blamed her postnatal depression for the deterioration in her marriage:

***It's very depressing when you realise that you are actually ... so negative and so miserable to live with, that your husband is***

**actually avoiding being at home with you. So he's working longer hours... and he's avoiding coming home.**

What becomes apparent here is not only the level of self-blame that some mothers experience but also the lack of self-worth. Fiona does not feel worthy of her husband's presence because she is "so miserable to live with".

Lucy experienced a similar scenario although her husband started having a relationship with another woman during her pregnancy and continued to do so for months after her baby was born:

**It was a very difficult pregnancy... I was heavy, I felt enormously unattractive... and he would get these phone calls and disappear for hours on end... That was the most painful experience I've ever had with him... I actually didn't want to be married to him anymore. He just carried on regardless... it was very stressful, it was really incredibly stressful and there was that tension when she was born, just as she was born... and he says, oh, it was my fault because I cut off from him and I wasn't involved with him...**

This raises the point previously addressed under "lack of support" where Mauthner (1998b) argues that perhaps some marital relationships become troubled not because the husband failed to give support to his wife, but because the wife withdrew from her husband and did not share her needs or expectations with him, leaving him ignorant of means to assisting her. While this may be true in some instances, other research has found that husbands were perceived by their partners to work longer hours and to be more absent than women in a control group who did not have postnatal depression. (Mills, Finchilescu & Lea, 1995). In other words, partners were not present enough to give the support needed by their wives.

Why are fathers often rated as absent and unsupportive? Fathers are not immune from the vicissitudes of childrearing. Just as the transition to motherhood is a significant life event with its concomitant upheaval of previous stable structures, so is the transition to fatherhood. When the father has to manage the added stress of a

depressed wife he could possibly become depressed himself (Terry et al., 1996). As with depression at other times in life, there is a higher prevalence of depression among women postnatally when compared to men especially in the first few months (Matthey et al., 2000). However, there is some evidence that the incidence of paternal depression may increase over the first year postpartum (Areias, Kumar, Barros & Figueiredo, 1996). As far as couple morbidity is concerned, when mothers are severely depressed, the incidence of partner depression has been found to increase significantly with levels reported at between 40% and 50% (Dean, Surtees & Sashidharan, 1983; Harvey & McGrath, 1988). In this sample of women suffering from postnatal depression it is likely to assume that at least some of the fathers may have been depressed themselves which is perhaps why they were not present and supportive of their wives. However, even if the men were not depressed, the impact of their partner's depression can take its toll. In a phenomenological study of 8 men whose wives had postnatal depression, it was found that as a result of the postnatal depression the men experienced a major disruption in their lives with feelings of being unable to "fix the problem" creating frustration and anger and fear of facing an uncertain future with a much changed spouse (Meighan, Davis, Thomas & Droppleman, 1999). Although the husbands thought that they had assumed increased responsibilities in terms of taking care of the wife, child and household, while still continuing to work, they felt their efforts went unnoticed and unacknowledged. As Jessie, in the present study, acknowledges, her expectations of her husband were impossible to meet:

It did not matter how great Dad was, he just wasn't good enough.

Marital change across the transition to parenthood has been attributed, in other studies, to the division of labour in the household. (Doucet, 1995; Gjerdingen & Chaloner, 1994a; Wicki, 1999). When a child enters the equation of the marital relationship, changes in instrumental role arrangements between husband and wife have to be renegotiated in order to accommodate for the added task of child care in the family (Belsky, Lang & Huston, 1986; Belsky et al., 1983). Instrumental roles, it is argued, become more traditional with husbands adopting more of the "traditionally male responsibilities" (caring for the exterior of the home, managing family finance) and sharing less in household and childcare tasks while wives take on the



“traditionally female responsibilities” of household and baby care to a greater extent (washing dishes, changing nappies, doing laundry) (Belsky et al., 1986). Furthermore, these trends were found to be independent of the wives’ employment status, (Hoffman, 1978, cited in Belsky et al., 1986) or of the couple’s pre-existing division of labour or sex role ideology (Stafford, Bachman & DiBona, 1977). Belsky et al. (1986) found that the more the division of labour between husband and wife changed towards traditionalism, the greater the decline in wives’ perceptions of the positive aspects of the marriage. The present study found support for these arguments. According to Jessie:

**The man-woman thing... made me angry because I didn't realise that... the roles are not equal. I thought they were. I mean I didn't expect Steven to drop his job and stay at home with me... but I just... it was very different, and that made me quite angry ... because it suddenly dawned on me that this is the way it is, just like they said they were.**

The pervasive theme of thwarted expectations emerges again here in that Jessie felt disappointed by the realisation that she and her husband were no different from “them” i.e., those people who comfortably assumed traditional sex roles. She expected herself and her husband to be different – but had to face up to the reality that they were no different from the traditional stereotypical family where the mother stays at home and looks after the children and the father goes out of the home to make a living. Her cognitive dissonance was resolved through assuming those traditional roles and changing her ideology on the division of labour – she resigned herself to the assumption that “this is the way it is”. No effort is made to question the status quo of traditional patriarchal roles. Indeed, Feldman and Nash (1984) demonstrated in their longitudinal study that following the birth of a child, women revise their previous sex role attitudes with regard to the division of labour in order to bring their perceptions more in line with their reality.

The present research highlighted an area of conflict in the marital relationship which has not been investigated in previous research. Namely, six of the women in this category felt that the source of conflict with their husbands/partners lay in the

women's resentment of their partners' lives which continued "as normal", while the women's lives were significantly restricted and profoundly changed by the birth of their child. Two examples reflect the sentiments expressed about this. Gaby says:

**I resented that his life carried on and mine absolutely stopped. So he was still going, doing things independently, and I was stuck in this house with the baby... that contributed a lot (to her PND). I was very resentful and envious of him.**

Elaine's partner actually left her when their daughter was a few months old:

**I guess he just couldn't take it anymore. I would just scream and shout at him... his life just carried on – he went to work, he saw his friends in the evening, his life didn't change – and I had to feel guilty about going to the toilet.**

For many of the women in this study their partner was the only person who was exposed to their experience of postnatal depression. When he was perceived as emotionally or physically absent the mothers' source of support vanished and, in addition to that, her feelings of low self-esteem, guilt and anger were exacerbated. Clearly the impact of the partner's involvement in the family is pivotal in the postnatal experience.

### **Relationship with Own Mother**

Another significant relationship which seems to play a vital role for the postnatally depressed mother is her relationship with her own mother. This category is an extremely complex and rich one. It is also one of the most popular reasons stated by the women in this sample for causing their postnatal depression (13 women). The most profound comments of this category relate to the need for these women to be mothered, nurtured or looked after by their own mothers. What these women realised, and what these women attribute their depression to, is their mothers' inability to read their needs. This inability arose either because their mothers were too self-involved or

because they simply did not know how to or, finally, because although their mothers thought they were meeting their needs, they were actually misreading them.

Amanda felt that her mother did not know how to mother her and this was reminiscent of her infancy and childhood when her mother was seldom available to give her what she needed:

**The main reason why I got depressed is, I think, the absent mother. I think when you have a child, it brings out so much of the child in you, and that my mother was just so utterly absent for me. And I think it brought out when I was a baby... when I was born, I was a twin and there was an older child, 16 months older. My mother probably didn't cope with us at all, and I think it brought out the lack of parenting when I was the age of my new-born son.**

Amanda is identifying with her new-born son's emotional experience through the eyes of her own mothering experience at that age. While consciously she is unlikely to remember her early mothering experience as an infant, it is through the birth of her son that these repressed or unconscious memories re-emerge and she almost takes on the emotional predisposition of her son.

Similarly, Patty says:

**I felt that I was dealing with this vulnerable little baby... in a way you kind of took on that vulnerability yourself and became like a little baby... needing, just longing for that kind of affirmation and I think that's where I felt the kind of loss of my mother's involvement.**

Ilana also says:

**There is a whole psychoanalytic thought about separation from the mother and that's why you become depressed...after the birth of your first child... or why some women do is it's an incomplete**

**separation, and I think there is a lot of truth in that respect. My mother just wasn't there... she was too old... and a lot of those issues came to the fore. So I don't think it was possible, I mean... if I'd never had a child, maybe I would never have had that kind of profound experience of depression.**

Feelings of abandonment, lack of attachment or incomplete separation seem to become extremely significant following childbirth. From a psychoanalytic perspective, following the birth of a child the new mother reassesses her relationship with her own mother. "Early experiences of satisfaction and frustration, of love and hate, have led to good and bad mother images which now colour the woman's representation of herself as a mother" (Breen, 1975, p. 26). Successful maturation leads to incorporation of a healthy mother image, but where identification with the good mother image is impossible or problematic and dynamics between mother and daughter remain unresolved, depression may ensue (Breen, 1975; Hopkins, et al., 1984).

Every woman in this category spoke of their disappointment with their own mothers in terms of mothering them. Louise Emanuel (1999) asserts that the reason that postnatal depression differs from other episodes of depression is because it is about taking on the mothering role and this, she says, "can have a direct link with the mother's own childhood experience of parenting, particularly her relationship with her mother" (p. 52). The adult's own experience of mothering in childhood is significantly associated with adjustment at the crucial time of transition into parenthood, when the role of mother is first adopted and can play a key role in postnatal depression (Boyce, Hickie & Parker, 1991; Matthey et al., 2000; Trad, 1994).

Thwarted expectations of one's mother be it in terms of her role as mother and/or grandmother gave rise to feelings of disappointment and resentment amongst many of the women. While many of the mothers in this sample of women thought they were helping their daughters not only were they not, but in not doing so they were seen as causing their daughter's postnatal depression. Betty says:

**My mom... wasn't what I expected. I wasn't getting... the mothering that I wanted – I wasn't being nurtured when I had to give out so much – in the way that I wanted to. She was doing things, but... not what I really wanted.**

Amanda, in a similar vein says:

**[My mother] was not around to make me a cup of tea, not there at night. I remember she said to me afterwards, "God, how many nights I took Michael off your hands". It was exactly two nights that she took him. Twice she took him. And in her head she took him many, many times. So in her head she thinks she's the good mother but the experience in the child, me, was that she was absolutely non-existent.**

Vanessa speaks for a lot of the women when she says of her mother:

**I think she sort of had the appearance of being the dutiful grandmother, but... really didn't want to know.**

Betty says of her mother:

**She just wasn't what I expected when I had kids. She wasn't a baby person... so she would actually merrily leave my house while both kids (twins) were screaming, and walk out and go home. But she would make meals and stuff. She would do what was easy for her. I would have rather bought more Woollies meals and had her take a baby for an hour a day.**

Women classified as being depressed postnatally have reported less support from their mothers both prenatally (O'Hara, Rehm & Campbell, 1983) and postnatally (Mills et al., 1995) than women not classified as suffering from postnatal depression. The essential question raised here is whether, as new moms, their expectations were too high of their own mothers? Walzer (1995) argues that the lack of mothering

experienced by daughters after childbirth may reflect the unattainable expectations that our culture places on mothers.

What informs the expectations that our culture places on mothers? The mass media plays a role in this but, more importantly, it is the extensive research in the mother-child field which is alluded to in mothering and childcare manuals. This research points to the need for a caring and responsive parent and the serious results of an absent (emotionally or physically) parent and how such events can result in depressed mothers. For example, Spitz (1945) investigated the impact of inadequate mothering on infants who were hospitalised and concludes that this would result in serious disturbances and possible morbidity. Another example is that of Bowlby (1951) who believed that in the absence of a continuous, intimate and enjoyable experience with one's mother, the child's development is "almost always retarded ... and symptoms of physical and mental illness may appear." (p. 11). Bowlby (1973) goes on to suggest that patterns of dysfunctional parenting are transmitted across generations because rejecting parents most probably experienced adverse relationships with their own parents during infancy. Bowlby's work has not gone without contention. Research in recent years has shown that deprivation of maternal care or adverse early experience in general does not necessarily have long term pathological effects on the child and that a number of other mediating factors need to be considered before universal statements such as those made by Bowlby prove true (Rutter, 1971, 1980, 1985, 1988; Werner & Smith, 1982). Furthermore, the pressure that is placed on mothers to be ever-present for their children feeds into the guilt that arises when they are unable to be with them all day such as when they have to go to work. This will be discussed later under "work issues".

Nevertheless, Norma Tracey (2000), in her paper on working with postnatally depressed mothers, found that the children of emotionally absent parents, who are unable to read or respond to their infant's signals and desires, are left feeling meaningless and dead. This, she says, "is what has happened to the depressed mother and it puts her in a position to repeat the cycle with her own infant." (Tracey, 2000, p. 191). Failure to intervene, she continues, is likely to perpetuate an intergenerational problem. Further evidence of the intergenerational transmission of depression between mothers and daughters comes from a study conducted by Miller, Warner,

Wickramaratne and Weissman (1999). They found that daughters of depressed mothers carry a childhood sensitivity, in the form of low self-esteem, into adulthood, which in turn is a risk factor for depression.

This legacy of lack of support is reflected in Vanessa's comments in the present study:

**I wouldn't mind if she were a paraplegic in a wheelchair, but if I could just talk to her. I don't need her to *do* anything for me. I don't think she wanted me to have it easier than she had had it in her time... and I remember talking at the time about how she would do it for the baby but not for me.**

By contrast to the mother who does not meet one's expectations, one woman in this study felt that her postnatal depression was caused, in part, by her mother who exceeded her expectations. This contributed to her postnatal depression, as it was perceived as threatening. Lucy explains this as follows:

**I remember my mother wanting to take her at night and look after her. "No". I said to her "No, I want to look after her". It was like my mother was going to take this child away from me and it was the strangest thing - I didn't want this child, I wanted to reject this child, but I could not let my mother take the child away from me... because... I was thinking about that recently actually... my father gave me a poodle... and my mother took over the poodle (laughter) and I'm sure that's where... if I give her this child, she will take it over like the poodle (laughter)... If I'd given her (her daughter) at night, I would have had no relationship with my daughter whatsoever, because my mother's incredibly nurturing.**

Matthey et al. (2000) found that daughters of overprotective and overcontrolling mothers were more at risk of suffering from postnatal depression in the early postnatal period. The commonly held belief that daughters become closer to their mothers following the birth of a child through a process of identifying with their mother

(Martell, 1990) was not supported in this study or in other studies (Walzer, 1995). As Walzer (1995) says, despite the social image of mothers being all-nurturing and all-holding of their daughters, many of the daughters felt, as in this study, a lack of these qualities in their mothers. Perhaps what is difficult to acknowledge for these daughters, is the possibility that the way in which their mothers relate to their new grandchildren is reminiscent of the way in which they were treated as infants. That being the case, they would have to acknowledge their own inadequate mothering experience which, at a time when one is needing holding and nurturing, can re-evoke a significant sense of loss and bereavement.

## **PSYCHOLOGICAL FACTORS**

### **Unresolved Trauma**

Unresolved trauma refers to women's experiences in their lives, from their childhood to the present day, which they, by their own admission, have not come to terms with. The unresolved traumas that the women spoke of were extremely varied in nature and severity. The two more common themes that emerged related to the impact of sexual abuse on postnatal depression and the perception of being inadequately parented as a child and how it contributed to the postnatal depression. Other unresolved traumas that were raised related to having been adopted, losing a child, having killed two men in a car accident and having experienced a miscarriage. Although extremely diverse experiences, at the core of each of them lies the shared perception that giving birth to a child is a metaphor for giving rise to repressed or unconscious issues – it can bring to the surface many of the unresolved and unspoken stuff of the past. Twelve women attributed their postnatal depression to unresolved issues, saying that had they tackled these experiences or issues before they had a child, they probably would not have got postnatal depression. Having kept these issues carefully tucked away for so many years, they now found that in giving birth they were forced to confront them.

As Carla says:



**I think there were a lot of issues in my life before I had Michelle – very traumatic and dramatic instances and issues that I had not dealt with at all on an emotional level, and ... when I had Michelle, being responsible for another life was the catalyst that brought out all these emotional issues... everything that I had never confronted.**

When a baby is born, the experience for a new mother can be overwhelming. Suddenly she is responsible for a helpless, totally dependent human being. This, at a time when she is sleep-deprived, perhaps in physical pain from the delivery as well as having to negotiate her new role as mother, can make her feel extremely vulnerable emotionally. This emotional vulnerability may elicit memories of previous vulnerable moments in her life which may never have been dealt with adequately on a psychological level. That these incidents or issues arise at a time when one is resourceless and vulnerable is not a coincidence. As Tracey (2000), in her psychodynamic work with depressed mothers argues, trauma resides in a sensory, physical and primitive area of our being and the primitive and physical event of childbirth could in itself unleash previous infantile, childhood or adolescent traumas which also reside in that same sensory, physical and primitive area.

Of great significance to 3 women in this sample, was having been sexually abused or raped in their childhood years. Indeed, countless studies refer to the association between sexual abuse in childhood and subsequent depression in adulthood (Brown, Harris & Eales, 1996; Moeller, Bachmann & Moeller, 1993; Mullen, Martin, Anderson, Romans & Herbison, 1996). For all of the women in this category, one of the predominant manifestations of their postnatal depression was, not surprisingly, tremendous anxiety about their children's well being. Debby felt that because of the abuse she experienced as a child, she had very little confidence in herself as a mother. In addition to this, she was scared of causing any psychological damage to her baby boy so that even changing his nappy became a crisis for her. She explains this as follows:

**...what was quite weird... it was a big thing for me I guess because of what happened... going to sound totally far fetched – but even**

**when I would change his nappy... I was scared that maybe I'm going to touch him in the wrong way, or do something I'm not supposed to do. That was very nervy for me because I mean, God, the last thing I'm going to do is ever do something to him that's going to... so I'm very, maybe sometimes overly conscious of psychologically damaging him, doing something like touching him in the wrong way, and I know that's got a lot to do with the abuse.**

Carla expresses something that all 3 women alluded to when she says:

**I was raped at 4 years old... and there does seem to be a certain amount of hidden blame with regards to my parents because how could this have happened in their home... you know if this had, God forbid, had to happen to my daughter, in my home, I ... pray to God, I like to believe, that I would know instantly. So there is a feeling of resentment that my own mother didn't pick it up, which has made me totally and utterly almost obsessed with Michelle.**

She goes on to say that the consequences of the rape emerged after having her own daughter because:

**at four years old you're not emotionally equipped to deal with the emotional aspect of that. So I... I probably have never dealt with the emotional aspect of that four-year old rape.**

Although Nair and Morrison (2000) state that mothers who have been abused in childhood are at an increased risk of abusing their own children, childhood rape, for all three of these women, seems to have elicited an obsessive need to take utmost responsibility for the care of their children so as to prevent them from experiencing any similar trauma.

With regard to unresolved issues about the way in which some of the women were raised by their parents, Natalie, for example, says:

**I was carrying a lot of anger around inside of me about the way in which I was raised... it wasn't an unhappy childhood but... because my parents are committed Christians... and because of their beliefs and their way of life, it was very restricting for us... I was deprived of so many things: I couldn't wear pants, I couldn't wear make-up, I couldn't go out to discos, I couldn't go to biscope, we never had a radio...I had to accept the fact that my parents did the best they could for me. But that [the PND] was just my voicing my anger ... dealing with all this anger I had towards my parents.**

Fiona says that although on the surface her parents were very stable, underneath that lay a lot of stress which created a difficult environment in which to be raised. She felt this was one of the main causes for her postnatal depression because, after having her own baby, she realised how vulnerable she herself must have been as a child, and how important it is for children to be brought up in a stress-free and emotionally comfortable environment.

**As a child I was brought up in a ... although it was happy and very sort of stable, it was a stressful environment. You know, a fiercely ambitious father, and my Mom was a real achiever, my Mom does everything right, and ... she doesn't go with the flow. So I didn't have a laid back childhood... it was quite stressful.**

Heidi is the daughter of a diplomat and was moved from country to country as her father took up different diplomatic positions. She raises this as one of her reasons for getting postnatal depression:

**I had quite an insecure childhood... wherever I was I tried to be this kind of chameleon... I always desperately wanted to fit in. I also became quite a perfectionist in terms of schoolwork because that was like how I could judge, or how my parents could judge... As far as they were concerned, if I was doing well at school then I was coping. But... I think it was just a very simplistic way for them to feel that I was coping, because actually I wasn't coping...I was**

**having nightmares, and I developed all kinds of anxieties about life and the world.**

For Heidi, that was the root of her anxiety but it was only after giving birth to her first child that she realised this and could start confronting it. The parenting that children receive and the unresolved issues stemming from their family of origin has a significant impact on their emotional, physical and social well-being (Nair & Morrison, 2000) and can render them vulnerable to postnatal depression (Gotlib et al., 1991; Gruen, 1990). Women's perceptions of being cared for by their parents, by contrast, offers them confidence in their ability to care for their own infants and protects them from experiencing postnatal depression (Gotlib et al., 1991). In particular, as mentioned previously, the mothering received in childhood and the ongoing relationship with one's mother is pivotal in the postnatal experience.

Sandra was adopted and when asked why she thought she got postnatal depression she said:

**I was adopted... which I didn't think was that much of a problem at the time but it's become more obvious that it was a problem in terms of loss and grieving and bonding and attachment. And my adoptive mother was going through her own crisis obviously at the time and had been through adopting me, and then adopting another little boy but then they took that little boy back after about a year. So her emotional giving to me was negative, it just wasn't there. And I think it's a protective thing – I've built up this strong independence and I'm afraid of being dependent on anything, afraid of being out of control, afraid of being in touch with anything, afraid of being in love with anything.... I don't think I dealt with any of these issues before. And as soon as you have – as an adopted person, me anyway, - as soon as I had Joshua, as soon as I had a baby, that just brought all that stuff like up to the surface like you cannot believe.**

Sandra's fear of attachment and loss was clearly brought to the fore by the birth of her child. She, herself, had to confront not only her own infantile experience of "losing" her biological mother, but also her adoptive mother's resistance to becoming attached to her because of her fear of losing her (because her adoptive brother was taken away). Now that she had her own baby to take care of, these unresolved issues of loss and attachment surfaced as the primary cause of her postnatal depression.

Amanda had lost her first child when he was eight days old and had not suffered from postnatal depression following that birth. However, after giving birth to her second child, who was perfectly healthy, she became severely depressed. When asked why she suffered from postnatal depression after the second child she said:

**I could not grieve the loss of my first child, until I had a baby in my arms. I could not... I could not go into that space... until I knew I had a child in my arms - a healthy child in my arms.**

It was at that point that she allowed her defences to crumble:

**The dam wall had broken from all the pain, all the suffering, all the pain of losing a child, the pain of carrying my first child for seven months in hell, losing him; went through the trauma of surgery, the trauma of falling pregnant, the trauma of losing a twin pregnancy, the trauma of a bad amnio result, the trauma of getting through my second pregnancy to try and get to a viable baby... those dam walls broke and I crashed. I couldn't keep up that strong, in control, okay Amanda anymore. My body just shut down.**

Again, the experience of many women is one of managing their situation psychologically or emotionally until this life-changing event that is childbirth unleashes the ghosts from one's past. In order to manage this unfolding of emotional events the mothers in this study spoke of their need for a supportive, non-judgemental environment in which they could express themselves freely and have their feelings contained. This theme thus related directly to that of "lack of support".

## Loss

Ten of the women in this study attributed their postnatal depression to what they called “loss”. Apart from one woman whose loss related to that of a previous child who had died, “loss” either referred to deeply missing the lifestyle they had enjoyed before having children or to a loss of identity. Gaby explains this sense of loss that she experienced as follows:

**I felt like I'd been in complete mourning. No one had ever expressed that word, I hadn't read it anywhere, I just one day thought yah, I feel like I'm mourning something, yah, I was mourning my past life. I couldn't accept that that had all gone. That's what it was in the beginning... that feeling of mourning.**

### *Loss of previous lifestyle*

Anticipating life with a first child can often result in disappointed expectations of the impact motherhood can have on one's life. The category of “unrealistic expectations” will be dealt with separately but for now it is important to note that when one is confronted with an experience that is markedly different to what one has expected, a sense of loss can be experienced. As in Lewis and Nicolson's (1988) study, some women in the present study found that full-time motherhood entailed a major shift in lifestyle which gave rise to feelings of loss of autonomy and independence in the face of the overwhelming responsibility that constitutes motherhood.

For Ilana, this was the key cause of her postnatal depression:

**At the heart of it was the complete loss of freedom. And I am somebody who had lived an extremely free life. I've always done what I wanted to do... like I gave up a really lucrative job because I wanted to study literature... I didn't have any dependants, I just did it. My husband and I are ... people that are not bothered about how much money we have... but you see now those things are**

**critical. So my freedom has gone in all sorts of ways... So I have no existential freedom at all and I think that's what it was about... I think that at the core it was ... you're no longer free.**

For Ilana, the responsibilities associated with having to take care of her child and no longer just herself and her husband, sabotaged her previous sense of freedom to move along through her life in whatever direction she chose. When speaking to her, as well as other women in this study, there was a strong sense of “life before child” being distinctly separate and different in nature and spirit to “life with child”. Life without children was, on the whole, described as free, active, busy, concerned with the pursuit of self-gratifying needs, independence, spontaneity and financial unaccountability. This was in stark contrast to life with a child which is often described as slow, monotonous, responsibility-laden, tied down and isolated.

Sandra, in this study, did not expect to lose so much of her previous lifestyle and this came as a shock to her:

**The most obvious... reason (for PND)... at the time was that I was a very busy person. I was always out doing stuff, I was involved in lots of different things and my work was really important to me, and I was very selfish with my time and incredibly independent and fought very hard for that. So that was a big loss... that was a huge sacrifice and a huge loss and I had absolutely no idea it was going to happen in the way that it happened, or feel the way that it felt when it happened.**

From a feminist perspective postpartum depression is theorised as a “normal” response to motherhood and is linked to “public-world” losses of identity, autonomy, independence, power, and paid employment (Mauthner, 1999). Having a baby, nevertheless, is conventionally perceived as a gain rather than a loss and the period of childbirth and early motherhood is typically one of physical and psychological adjustment.

Such critical changes in the life course, which demand physical and psychological adjustment to loss (e.g., dying, divorce, bereavement) have been recognised by authors such as Murray-Parkes (1980) as periods of emotional lability, throughout which grief needs to be negotiated (cited in Nicolson, 1990). According to Nicolson (1990), childbirth and early motherhood fits into this model of loss because mothers have to confront the loss of many aspects of their lives from that of body-image and psychological identity (Nicolson, 1990) to loss of freedom, spontaneity and control (Gruen, 1990) to loss of career status and an exclusive relationship with one's partner (Gair, 1999) and loss of autonomy (Priel & Besser, 1999). Furthermore, Nicolson (1998), in her later study on becoming and being a mother, found that women described a series of losses which they often perceived as an individual pathological reaction because of the popular discourse of motherhood as a "happy event". This, she says, sometimes leads women to describe themselves as having postnatal depression. This socially constructed image of motherhood will be discussed later under "the myth of motherhood".

### *Loss of identity*

The experience of loss of identity refers to those seven women in the sample who felt that since becoming a mother they had to re-evaluate, for themselves, who they were in terms of their identity. As Tracey (2000) explains: "The depressed mother... has lost her central core of identity. She seems not to have a meaning or value for herself as mother to her infant; she seems to be in mourning, as if she had suffered a terrible loss" (pp. 185/6).

Jessie states categorically that her postnatal depression was the culmination of an identity crisis after having her son:

**With me it was an identity crisis. I felt that I lost who I was – I had no idea who I was because obviously I felt I really didn't know how to do this right (i.e., being a mother)... Suddenly I wasn't somebody that knew what they were doing anymore. I just suddenly didn't know who I was anymore; I didn't know what kind of a wife I was**



**either... you know, what kind of a friend am I, what kind of a ... woman... suddenly I just didn't know who I was, at all.**

Jessie had previously worked in the corporate fashion advertising and journalistic field – a particularly fast-moving and exciting job that involves a lot of contact with other people and exposure to world-wide trends in the fashion industry. When she had her daughter she suddenly and unexpectedly felt out of her depths – she didn't know “how to do this right” and she couldn't work out who she was anymore in relation to the significant people in her life – her child, her husband, her friends and herself. It seems that suddenly her life came to an abrupt standstill. Everything that had previously seemed so important (her job, her ability to keep her finger on the pulse of fashion etc) no longer counted. What did count suddenly were her relationships with people around her – her support system, her child and her sense of self. For women who have always defined their competence in terms of the workplace, the prospect of staying at home and mothering seems especially daunting because there is no prescribed right way of doing it or associated reward for good performance. Furthermore, self-critical women, according to Priel and Besser (1999), are likely to be especially self-critical when facing motherhood because it involves the assumption of a new, unexplored role which is extremely challenging. Like Jessie, many women feel incompetent in this new role which may be especially difficult for those who define themselves in terms of competence (Priel & Besser, 1999). Perceived incompetence, in turn, leads to a lowered self-esteem which may negatively permeate many aspects of their lives from relationships to the absence of paid work and becoming a housewife (Usher, 1992b).

Fiona felt that in the absence of her high-powered fashion job she lost her sense of self-worth and acknowledgement:

**My whole identity had changed. I missed the frivolity of actually waking up in the morning and getting really dressed up, and my suit, and my expensive cosmetics and my make-up and everything... and zooting off to work, and the appointments... people taking me seriously. Suddenly it was like, nothing I did was valued, or no-one really cared – that I did my bloody... shopping,**

**and no-one cared about what I did – I was arbitrary – and I just – oh- it was painful.**

The causes of postnatal depression that are related to work issues will be discussed later under “work issues”. What is relevant for now, in this section of loss, is Fiona’s sense of becoming “invisible” to others once her baby was born. A similar finding was reported by Lewis and Nicolson (1998) in their study on early motherhood and the recognition of loss. They argue that this results from partners, relatives and friends identifying women as “mothers”. By defining women only in relation to their children, any sense of personal or autonomous identity is lost. Consequently, motherhood is constructed in unidimensional terms, thereby ignoring the experience of motherhood as one among many other facets of a woman’s life and identity (Lewis & Nicolson, 1998).

Gaby echoes this sentiment:

**I mean you got a lot of your identity from being out there in the world, and suddenly you are, well you feel like no-one remembers you exist.**

The importance of investigating women’s understanding of the cause of their postnatal depression once they have recovered from the episode is of particular importance in this category because mothers of young babies may be too overwhelmed by the demands of new motherhood and its associated exhaustion to acknowledge that they are experiencing any loss. Lewis and Nicolson (1998) emphasise that while some women in their study experienced losses and difficulties in motherhood, it was only in retrospect that they could make sense of those feelings in terms of a loss and grieving process.

## Personality Factors

A number of personality factors were ascribed as a cause of postnatal depression such as being a perfectionist, a caretaker or a rigid-minded person. The personality factor that predominated, however, was that of control. Eleven of the women in the present study attributed their postnatal depression to feelings of lack of control. In addition to their need for control over their thoughts, actions and feelings, this theme refers to women's expressions of their need for order, routine, predictability and structure in their daily lives as well as the need for order in terms of cleanliness and organisation in their homes.

Having a baby, for these women, threw disarray into their organised routines and sense of control of outcomes. As Fiona says:

**I like to know that, you know, if I feed her that she's going to be healthy. And if I teach her this, and I bring her up like this, she's going to be a lovely person.**

Carla, a journalist, felt out of control of her life for the first time ever after her baby was born:

**When you've got a 250-word article to do, you know that when you start on the first word, you've got another 249 to go, and there's a beginning and an end. But with a human life... it's totally... it's unpredictable.... There wasn't supposed to be colic, I hadn't planned for that... there wasn't supposed to be constipation, I hadn't planned for that. So all of these unknown entities that were brought into my immediate situation in my very limited time that I had to spend with her, because I had to get back to work, threw me out completely, and not being in control of something for the first time in my life, knocked me for a ball... the anxiety just snowballed into every aspect of my life.**

To mother children is to enter the world of unpredictability and uncertainty. As Terry (1991) says, the belief that one has the capacity to control the outcome of life events may not be very helpful in the context of new parenthood, given that looking after a new baby is an event that has little potential for control. Beck (1993), in her qualitative research, found that loss of control was the basic social psychological problem with postnatal depression. She refers to the women in her research lacking control over their emotions, thought processes and actions.

For Heidi, feeling out of control elicited childhood feelings of her lack of power and agency in her own life. As mentioned before, she is the daughter of a diplomat who was posted to different locations frequently:

**Feeling out of control is a huge thing... as a child, I was never given a sense of even a small part of my world being within my control. Because my parents were... the controllers, you know, they used to control what toys I took with me when we moved, what books had to stay behind, what books would go, the pets had to stay behind... and the friends stayed behind, so I was never able to feel empowered in any way, and this kind of unplanned pregnancy, and a child who you could never put down for a second, it was just all... fed into that sense of being out of control... which was very scary...**

The need for control can be very powerful for some women and this is reflected in Natalie's story:

**My house had to be spotless... and I used to become irritated with the baby because he was crying because he wanted to be fed, or maybe he wanted a cuddle, or he had a wind, or whatever – because he was interfering with my cleaning the house. Nobody was coming to visit. ... There was one day when – I'll never forget it – I was at the kitchen sink washing the dishes, washing the cutlery to be more exact... and I just got this urge to take the knife that I was washing, and just... stick it into my child.**

Thoughts of harming the infant are not uncommon in mothers with postpartum depression (Jennings, Ross, Popper & Elmore, 1999). For Natalie, however, order and cleanliness in her home was perhaps the one area of her life over which she felt she had control since having a baby. Her obsession with maintaining that order on an external level while her internal world was falling apart almost cost her the life of her baby. The women in this category seem to have always relied on external order to control their internal disorder. Without a structured routine and an organised home they would feel anxious because such disorder would mirror their internal experience of feeling out of control. With a baby, however, internal issues get challenged even more and the defence these women have always harnessed of external order is suddenly removed with the unpredictability of events that comes with having a baby (e.g., it is impossible to completely control when the baby will sleep, eat, feel uncomfortable, need to be held, get sick etc.). Thus, once the obsessive-compulsive need for external control is unable to be met, the anxiety that the women experience is exacerbated and can contribute significantly to their postnatal depression.

### **Stressors**

Stressors refer to life events around the time of the postnatal depression, which were stated by the women as causes of their postnatal depression. From a psychological perspective this category would fit into the diathesis-stress model of depression. An underlying assumption of the diathesis-stress model is that vulnerability to depression is actuated by stressful life events. This model thus posits various examples of diatheses or vulnerability variables that are associated with an increased risk of postnatal depression. Eight of the women in this study attributed their postnatal depression to life stressors of various kinds ranging from financial stress to renovating homes to a family member facing fraud charges. For all of these women it was these events which, compounded by their vulnerable emotional state, provided the catalyst that tipped them from a difficult but manageable existence into postnatal depression.

As Fiona says:

**My parents separated after 33 years and that threw me again. It was a total shock to me... that was the catalyst because then, at that point, when my parents separated, I couldn't cope.**

Rachel, in addition to two other women, spoke about the impact of financial stress:

**The other huge one (i.e., cause) is money. There is still no solid income and we still don't know where next month's coming from... it's been with us ever since Sarah was born and I find that it's wearing me down... absolutely... cell by cell. It's just one of those things that is another stress and with all those other things ... just another weight.**

Childbirth and the transition to motherhood constitute a normal stressful life event (Priel and Besser, 1999). The experience of additional stressors at the time of birth, or even in the period preceding the birth of a child, can have a more marked effect on the mother's adjustment than if that stressor had occurred in isolation (Hopkins, Campbell & Marcus 1987; Lazarus & Folkman, 1984). There is support for this proposal, in that the accumulation of recent and concurrent stressors (other than the birth) has been linked to levels of maternal depression (Hopkins et al., 1984; O'Hara et al., 1983; Paykel et al., 1980) and the incidence of parenting problems (Terry, 1991). More recent studies confirm that the experience of stressful events other than the birth across the puerperium appears to be a risk factor for subsequent depression (Da Costa, Larouche, Dritsa & Brender, 2000; Terry et al., 1996). These results can be attributed to the depletion of coping strategies and coping resources that is likely to occur under such circumstances (Da Costa et al., 2000; Lazarus & Folkman, 1984).

Interestingly, Amanda experienced multiple stressors around the time of her son's birth and, in particular, in the years preceding his birth but she feels that while these may have exacerbated her postnatal depression, they did not cause it:

**I had been through a divorce, a new marriage, moved house, lost a child, had huge financial problems and all the losses that I've previously described. And yet, if I had none of those life stressors, would I have got it (PND)? Yes.**

In other words, for some women additional stressors seem to be the pivotal factor in their postnatal experience but for others, like Amanda, they are not. Amanda argues that her postnatal depression had a strong biological basis that made the depression unavoidable. Thus, even in the absence of stressful life events, she felt that her postnatal depression was inevitable.

## **MOTHERHOOD**

### **Pregnancy**

A number of studies have found that depression during pregnancy is one of the most stable predictors of postnatal depression (Da Costa et al., 2000; Gotlib et al., 1991; Matthey et al., 2000). However, this was not the case in the present study. Only three women spoke about their pregnancies as being the start of their postnatal depression. Although this is not a large percentage of the sample, they regarded this as significantly related to their postnatal depression and hence this theme warrants attention. Studies have attributed depression during pregnancy to biochemical changes in the body (Kaplan, 1983), a poor relationship with the husband (Dimitrovsky et al., 1987; Richards, 1990) and lack of support (Da Costa et al., 2000). This was not the experience of the women in the current study. Rather, all of the women in this category experienced their pregnancy as traumatic either because of miscarriage, infertility or the fear of losing their child.

One year after her son was born, Natalie had an ectopic pregnancy which resulted in her having to have a Caesarean section to remove one ovary. That elicited strong feelings about a previous miscarriage from before her son was born which she had never fully processed. Although she was already in the throes of her postnatal depression she says that that whole experience:

**knocked me for a six... this just took me right back down.**

A miscarriage for some women can be extremely traumatic and tantamount to losing a child. What seems important is that adequate counselling is provided after a miscarriage so that the importance of that pregnancy, the loss and acknowledgement of all the feelings that come with that loss are sufficiently processed and acknowledged. A recent study also found that women most at risk of depressive symptoms after a miscarriage are those who do not conceive or give birth by one year after the loss (Swanson, 2000). Natalie, however, had conceived within a year after the miscarriage and hence this finding is not supported by her experience.

Betty had a very different experience. She had to go through two and a half years of fertility treatment before becoming pregnant with twins. She attributes her postnatal depression to the lack of support and counselling during those years of failed fertility procedures:

**One of the reasons I got postnatal depression is that I had fertility treatment and I got no counselling at the time. I just went through all the fertility treatment and that was horrific... it was two and a half years of being let down every single month and a lot of painful treatment... and you see... when I had the kids I thought to myself do I need any counselling about the fertility thing? But then I kept thinking: but it's resolved! I've got the kids now... I had a problem but it's gone now. But I don't know if ... all the pain, at the time, just vanished when I got the kids. And then the thing about under-investing or over-investing... I had over-planned children because I couldn't have them. So I think there was unresolved stuff about the infertility.**

Couples who experience infertility are grieving a loss – that loss is of the expectation of the vast majority of young couples that at some stage they will have children. For some couples this expectation will never be met, while for others, like Betty, there may be a delay in meeting it. When one eventually succeeds in having a child that has



been planned and anticipated for years it may be particularly difficult to accept negative feelings around the experience. In Betty's case, she had twins and she had wished and planned for these children for so many years that she was committed to making the experience of mothering what she had always dreamed of – she was going to be a “perfect mom”. To this extent she was determined, and succeeded, to breast feed her twins for two years – a feat most mothers of twins cannot manage for a month. She was also determined to enjoy every moment with them. When negative feelings started to emerge she felt unjustified in expressing them – after all, as she says, she now *had* her children. She felt that if she did air any negative thoughts she would be seen as ungrateful for her blessing of twins. She also felt that if she did not mother them “properly” she would be seen as undeserving of these miracle children. Thus, in her view, her postnatal depression was linked directly to her lack of counselling during and after the fertility treatment where such thoughts and feelings could have been dealt with in a non-judgmental framework. A number of authors emphasise the importance of infertility counselling during this period (Batterman, 1985; Berg & Wilson, 1991; Ellis, 1982; Valentine, 1986). This is because infertility is similar to a death and thus, like other emotional crises, requires grief work in the form of counselling (Daniels, 1993).

Finally Amanda, who had lost her first son due to an abnormal uterus, experienced her pregnancy preceding her postnatal depression as terrifying because of her fear of losing another child. She explains this as follows:

**I lost my son... six weeks later I had x-rays to find out I had an abnormal uterus... six weeks later I had surgery and then started trying to fall pregnant. So everything was utterly utterly anxiety-ridden... the whole way. I fell pregnant but now I had to lie on bed-rest for that whole pregnancy to carry this little child.**

She goes into great detail about her fear of losing this child:

**Will I carry this pregnancy, is it going to last? Every single day of that pregnancy was anxiety ridden. And then came the triple A test and I was told that I had a one in 17 chance of having a**

**Downe's Syndrome child... and then the amnio... waiting for those results in utter utter trepidation because my sister-in-law had just had a Downe's syndrome child.**

The difficulty of Amanda's pregnancy is made all the more obvious as she continues to describe in intricate detail every week of her pregnancy leading to the birth of her healthy child. It was following that birth that she experienced her postnatal depression:

**I kept on saying I lost a child and I didn't get depressed and then I had a child, and then I got depressed...**

Amanda's experience supports the findings of a recent study which found that vulnerability to depression and anxiety in the next pregnancy and puerperium following a stillbirth (pregnancy which ends in loss after 18 weeks' gestation) is related to time since stillbirth. More specifically, women who had a gap of less than 12 months between loss and conception showing a trend towards higher depression and anxiety not only during the next pregnancy but also one year after the next birth (Hughes, Turton & Evans, 1999). Women are hence cautioned to mourn the lost child and wait 12 months before the next conception because the process of grief and mourning may last for at least a year or more (Forrest, Standish & Baum, 1982; Hughes et al., 1999).

Anxiety during pregnancy is not uncommon. Lubin, Gardener & Roth (1975) found that anxiety during pregnancy followed a U-shaped pattern with increased anxiety in the first and last trimester, and reduced anxiety in the second trimester. Elliott, Rugg, Watson & Brough (1983) argue that they did not find a similar U-shaped pattern of anxiety over the three trimesters of pregnancy. They did, however, find that in late pregnancy women experience increased apprehension and anxiety about labour and delivery. Amanda's anxiety was naturally exacerbated by her previous trauma and her labour and delivery were particularly anxiety-provoking due to her previous experience.

Amanda continues to describe in her own words the experience of a post-traumatic stress disorder (PTSD) once her healthy child was born. Although no studies on PTSD during pregnancy were found, a recent study by Czarnocka & Slade (2000), looked at the incidence of PTSD following childbirth. PTSD is characterised by symptoms of re-experiencing of a trauma, avoidance of reminders and hyperarousal. It is experienced as “intense fear, helplessness or horror to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury... or threat of death or injury experienced by a family member” (Czarnocka & Slade, 2000, p. 36). In Amanda’s first pregnancy not only did she nearly die of internal haemorrhaging but her child died several days after delivery and hence, her potential for the experience of PTSD was almost certain. Bearing in mind the oft-experienced anxiety of pregnancy, the higher incidence of depression if conception occurs within a year of a previous stillbirth and the potential risk of PTSD following delivery, Amanda’s experience of postnatal depression is not surprising. In addition to pregnancy itself, the childbirth experience can play a very important role in the development of postnatal depression, as will now be discussed.

### **Birth Experience**

Eleven of the 20 women in this sample spoke about their birth experience as being one of the causes of their postnatal depression. Most of them went into great detail and spoke passionately about their deliveries and immediate postnatal experience. All of these women felt that their expectations of the birthing experience had not been met in terms of one or more of the following three areas:

- a) expecting to feel more satisfied with the delivery
- b) expecting to be supported and encouraged by the medical professionals
- c) expecting to feel an attachment to their baby immediately after delivery

### *The delivery*

Many of the women had not anticipated feeling what they had felt during the delivery process. They were very disappointed either that they did not have a natural delivery or, even when they did have a natural delivery, it was not what they had expected. The relationship between stressful deliveries and postnatal depression has been investigated in a number of studies which have produced inconsistent results. While some studies have found that women with postnatal depression had less stressful deliveries (O'Hara, 1986; Paykel et al., 1980; Seguin et al., 1999) others found that when delivery was more difficult than expected, it impacted significantly on postnatal depression (Bergant, Heim, Ulmer & Illmensee, 1999; Hannah, Adams, Lee & Glover, 1992; Romito, 1990). The latter seemed to hold true for the women in this study who perceived their difficult delivery experience as a cause of their postnatal depression.

Elaine talks about her birth experience:

**I'd planned to have a natural birth... and it was nothing like I was expecting... that was very disappointing, very frightening.**

Fiona also expected to have a natural delivery:

**I didn't want an epidural because... I wanted to do it the natural way... I mean my Mom could do it, I can do it you know... and it was very painful... I was vomiting throughout the process ... all over myself... and it was just the most scary, traumatic... I just want to forget about that.**

For the women in this study a "natural" delivery seems to refer to a vaginal delivery without any form of pain relief or medical intervention. Anything less than that (e.g., forceps delivery, suction delivery, an epidural or a Caesarean section) would constitute a failure in the birthing experience - would not meet their expectations of themselves.

Perceptions of the ultimate birthing experience being a natural delivery were powerful amongst the women in this study. What informs these perceptions? One source of information about the birthing process comes from antenatal lessons. Enkin (1982) argues, however, that the major source of childbirth education comes from the “totality of a woman’s experience, the cultural expectations of her society, the folklore and all other influences to which she has been exposed since her own birth” (p. 151). Fiona (above) was clearly informed by her mother who did it “the natural way” and if her mother could do it then there should be no reason why she shouldn’t be able to. Perhaps Fiona’s mother was very proud of her successful natural deliveries and in talking about her experience made Fiona feel that anything other than that would constitute a disappointment or a failure.

Many women receive a wealth of information about the birthing experience and yet continue to have unrealistic expectations about it and are ill-prepared for the event. Astbury (1980) argues that childbirth is such a stressful experience which arouses unexpected anxieties that it cannot be ameliorated through the rational, conscious means adopted by childbirth education. This is in stark contrast to Lamaze (1970) who assured women that prepared childbirth training would eliminate labour pain. Melzack (1984), in his research, qualifies Lamaze’s statement by saying that while pain may be diminished with antenatal training, it still remains severe. He continues to assert that if mothers are presented with realistic expectations of the labour experience, the possibility of disappointment, guilt and a sense of failure are reduced. A number of studies have investigated the congruence, or lack thereof, of expectations to reality in childbirth. Whether women receive antenatal training or not or whether it is their first or second child, studies consistently point to the fact that expectations are violated by the actual delivery experience (Astbury, 1980; Fridh & Gaston-Johansson, 1990; Knight & Thirkettle, 1987).

The next question that arises is why should violated expectations of childbirth render women vulnerable to postnatal depression? Terry et al. (1996) argue that a difficult birth experience is a potential source of stress for new mothers because they may interpret the experience as a reflection of their inability to cope with the demands of motherhood. Colman and Colman (1971, cited in Schroeder, 1985) similarly postulate that when expectations of childbirth do not match actual performance, self-esteem is

compromised and this may produce difficulties in assuming the mothering role with confidence.

Others highlight the importance of feeling a sense of control in the birthing experience (Elliot, Andersen, Brough, Watson & Rugg, 1984; Oakley, 1980; Romito, 1990). Control, according to Schroeder (1985), refers to active participation during labour and delivery versus being a passive object. Losing control, she says, refers to a kind of dependence in which one feels helpless and is forced to rely on the staff to control the events of childbirth.

Rachel describes her birth experience as follows:

**I wanted to have a natural birth. But in the end it was... the most revolting experience of my life, which I think was a major cause of what happened afterwards (i.e., the PND)... it was just so awful and so ... unexpected and so painful and so out of control that... it was devastating for me, absolutely.**

Where a sense of control, or its absence, is particularly pertinent is in the case of women who have to have emergency Caesarean sections. The unpredictability and shock of an emergency Caesarean section renders women helpless during the delivery and this experience can contribute to a sense of failure in childbirth (Affonso & Stichler, 1980; Romito, 1990). Durik, Shibley Hyde and Clark (2000) explain that there is “considerable social and psychological significance attached to having a surgical rather than a vaginal delivery. Cultural beliefs about womanhood include the idea that motherhood and, more specifically, childbirth are among the most natural experiences a woman will ever encounter... women who deliver surgically may feel they have in some sense failed and may even question their adequacy as mothers” (p. 258). This is corroborated by Heidi:

**I found the caesarean very horrific... I hadn't prepared myself for it... I hadn't considered the possibility... it was just like, oh no, what a failure.**

Indeed, research confirms that women who have emergency Caesarean sections experience far more stress (Grussu, Nasta, Sichel & Cerutti, 1999), rate the delivery as far less satisfying (Waldenstrom, 1999) and are more prone to postnatal depression (Edwards et al., 1994) than women who have natural deliveries. Furthermore, although there is no evidence of decrements in infants' psychosocial functioning associated with caesarean delivery (Durik et al., 2000), studies have shown that the mother-infant interaction following Caesarean section delivery can be affected with some mothers reporting indifference towards their babies at first contact (Garel et al., 1987) or experiencing too much pain to enjoy their first mother-infant contact ((Tulman, 1986) or having delayed contact with their infants (Romito, 1990; Zare-Parsi, 1989). Wendy, in this study, had an epidural Caesarean section and was unable to make contact with her daughter for many hours after she was born because her daughter was placed in an incubator and she was unable to walk due to the anaesthetic in her lower body. She says this has caused her a lot of emotional pain:

**...I lay there the whole day with nothing happening and still having no sensation in my legs. And nobody offered to take me to her, or bring her to me, so I don't know how long she was in the incubator for... if I sit and think about it, I still get a bit emotional, and I feel quite guilty, because I feel... I failed her by not being at her side.**

Amanda's birth experience was different to those previously mentioned in that, as mentioned earlier, she had lost her first baby eight days after he was born and, because of that, found giving birth to her second child extremely frightening:

**It was a very, very terrifying birth... very traumatic, unbearable... I was lying there having an epidural and anticipating whether he would be alive, whether he would make it, whether he would be normal... it was the most unbearable, unbearable birth.**

No form or extent of childbirth education could prepare a woman for the kind of experience that Amanda had. For her, childbirth was a life and death situation. It was her fear of the unknown that so terrified her and no-one could provide her with the

reassurance she needed because no-one was certain she would deliver a healthy baby. While death of a child during childbirth is not a “natural” phenomenon, it certainly is not unusual. In the same way as having to deliver via Caesarean section may not be natural, it certainly is common and thus should be included within the gamut of the normal birthing experience.

### ***Professional medical staff***

Some of the women felt that their obstetricians or the midwives in the clinics were not supportive or encouraging during their deliveries and this was a great disappointment for them and was associated with the cause of their postnatal depression. Gaby’s gynaecologist was away at the time of her child’s birth and she says of his replacement:

**I was really looking forward to the birth. It was totally natural, I didn’t have pain relief, it was quick, but this man sort of moaned the whole way through that I was keeping him up and not pushing properly, and blah, blah, blah.**

Elaine felt that her lack of support during the birthing contributed to her postnatal depression:

**I’d planned to have a natural birth ... and it was nothing like I was expecting. I was expecting that there were going to be nurses there, sort of holding my hand, and showing me how to breathe, and being supportive and all they did was strap me to a bed and disappear... the birth experience was very disappointing, very frightening... I think that contributed (to her PND).**

Fiona’s experience was similar to Elaine’s in that she also felt abandoned by the medical staff at a time when she was needing reassurance and support:



**No-one even explained to me... no one said, "I'm going to rupture membranes now, and you are going to go into third stage labour, which is very painful immediately – and prepare yourself for that." He just ruptured my membranes and left, and they came back in a few hours' time.**

Expectations of a supportive, caring and encouraging environment during the birthing process were clearly not met for these women. Studies on support from a labour companion, be it one's partner (Gjerdingen et al., 1991; Henneborn & Cojan, 1975), a constant labour companion previously unknown to the woman (Klaus, Kennell, Robertson & Sosa, 1986) or professional care from medical staff or a midwife (Czarnocka & Slade, 2000; Halldorsdottir & Karlsdottir, 1996; Mauthner, 1997) have consistently concluded that where there is dedicated support during labour and delivery, women experience less pain, fewer complications of childbirth and less postnatal depression. In the present study women referred specifically and exclusively to lack of support from medical staff – be it their gynaecologist or midwifery staff – as disappointing and contributing to their postnatal depression. Halldorsdottir & Karlsdottir's (1996) definition of the caring nurse-midwife encompasses the essence of what women in this study felt was lacking from their midwives and/or gynaecologist/obstetrician. They say that a caring nurse-midwife "is competent and committed to the provision of personalised care during labour and delivery, and knows how to safeguard the personal integrity and dignity of each woman" (Halldorsdottir & Karlsdottir, 1996, p. 365).

These situations, according to the women in this study, could clearly have been avoided by attending adequately to the women: by giving them information of the procedures they were to endure and by giving them support and encouragement throughout the labour and delivery. By remaining attentive to their needs and allowing them some sense of agency in the birthing event, women would feel less abandoned and less expected to cope with the experience alone.

### *Attachment/ bonding*

Four of the women in this category felt disappointed with themselves because they did not feel an immediate attachment to their babies. Mauthner (1998a), in her qualitative study on the experience of postnatal depression, also found that some women expressed disappointment at not feeling an immediate and instinctive attachment to their babies.

Gaby says:

**I felt absolutely nothing when Liam was born, which I wasn't expecting because I mean I usually do, you know, I mean I cry when I watch births on T.V. but myself, nothing. So I think I was disappointed with that.**

Again the pervasive theme of expectations is raised – the expectation of an immediate “bonding” with one’s baby. There seems to be a common expectation that the natural, normal and instinctive response to childbirth is an immediate sense of attachment and love for the baby. This is obviously not always the case and when this expectation does not materialise the mother may experience a sense of disappointment. The disappointment may be twofold. Firstly, for herself, Gaby may perceive her lack of feeling for Liam after his birth as an indication that she will not feel attached to him in the future. Secondly, for Liam, she may feel that because she did not experience the fabled surge of maternal love at his birth she has robbed him of that experience and perhaps done him some form of disservice or damage. Despite the folklore around bonding and attachment at childbirth, evidence points to the fact that maternal feelings in the immediate postpartum period are highly variable and an immediate bonding experience is not a precondition for the growth of maternal love over time (Maushart, 1997).

Lucy’s experience combines the previous category of professional staff with this category of attachment. With her first child, a boy, she felt an immediate attachment but when she had her second child, a girl, it was a different experience altogether and it was after this birth that she got postnatal depression:

**With Daniel, to this day, I can remember that little face when I first saw him. I never saw Stephanie when she was born... She was a caesarean ... she was completely indigo blue when she came out... and then they didn't show her to me. I said I want to see this baby and they kept on showing me her bum, twice they did that. I said I want to see her. They said it's a girl. I knew it was a girl... but I said I wanted to see this child and they kept on showing me her bottom.**

Obstetricians show the bottom of the baby so as to exhibit the sex of the child to the mother. In Lucy's case, however, she had known what the gender of her baby was and she felt cheated of an opportunity to "bond" with her daughter because her requests to look at her daughter were continually ignored by the doctor. This moment of seeing her child for the first time, which was of such significance to her with her first child, was completely lost with her second child. She spoke about mourning that loss and the difficulty of having to come to terms with the fact that her wish to see her daughter as soon as she was born was not respected and fulfilled by the medical staff. It felt, for Lucy, like a moment that was lost forever and she feels it has had a negative effect on her relationship with her daughter and impacted on her postnatal depression.

### **Mothering Issues**

Mothering issues refers to those reasons given for postnatal depression which are specific to being a mother, such as breastfeeding, sick children, failure as a mother and unrealistic expectations of motherhood. In total 17 of the 20 women in this sample specified this theme, in its broad sense, as the cause of their postnatal depression. In other words, these women implied that they would never have become depressed had they not had their children. What makes postnatal depression different from other experiences of clinical depression in this case, is the presence of a totally dependent infant who is the woman's responsibility in full – she, as the mother, feels entirely responsible for her baby's sustenance, emotional well-being and physical maintenance – an awesome responsibility in the face of a clinical depression.

Carla illustrates this as follows:

**For the first time in my life, with the birth of my child... I felt a feeling that I didn't know what it was, which was this absolute elation – and with that elation, because for the first time I had something so important to me, and that I was responsible for – came the fear. It was an emotion that I didn't know anything about, this intense love, intense responsibility, this intense, overwhelming admiration and awe, and this life... and the fear of me being responsible for all those things. And if I was not together, if I failed, I wouldn't just be failing... me, the consequence of my failure would be the well-being of my child. And I think that is what absolutely pushed me over the edge.**

### ***Breastfeeding***

Twenty five percent of women in this category found breastfeeding to be one of the main causes for their postnatal depression. Society places tremendous pressure on women to breastfeed their children with slogans and posters displayed on the walls of breastfeeding clinics such as “Breast is Best”. Breast milk, it is argued, has unique properties which are essential to infants' health and the physical act of breastfeeding encourages bonding between mother and child. Yet for many women, breastfeeding is a terribly painful and extremely demanding job that saps them of their confidence in mothering, depletes them of their energy and causes tremendous stress. Ilana tells her story:

**The really difficult thing for me was... the breastfeeding was a complete nightmare... from the beginning (tearful)...I have very inverted nipples and very white skin and very pink nipples and ... they are the most problematic kind and breastfeeding was just a nightmare from the beginning. The first time that I fed her in the hospital, one of the midwives helped me with my inverted nipples**

**– she tried to pull my nipple out and the blood came out of the nipple... when I saw that I actually should have known that that was an indication of how things were going to go – sweating blood to feed this baby. But there was so much pressure... you must try this, you must try that and I must try. The worst thing for me was the breastfeeding and having the courage to give it up.**

When asked why breastfeeding was so important to her, Ilana said:

**Because I was attending the breastfeeding clinic and I needed that support so badly 'cos I didn't have anyone here, no mother, no nobody and I knew ... that if I gave up breastfeeding, maybe I wouldn't be able to go to the clinic... I think it was also partly trying to be a good mother (tearful)... I just wanted to do the best for her and I knew that I was depressed and I knew I was having difficulty relating to her and bonding with her and I just thought that the breastfeeding is ... the best that I can do... (crying) and it was just a nightmare.**

Ilana felt that the one place she could receive support during the postpartum period was at the breastfeeding clinic. Her fear was that if she was unable to breastfeed then she would not be able to attend the clinic and then her soul source of support would disappear. Breastfeeding also provided Ilana with a concrete task that would benefit her daughter at a time when she felt she had nothing more to give of herself to her daughter. Her inability to do so elicited feelings of failing her daughter and of not being a good enough mother to her.

Heidi's baby had to be fed through a nasogastric tube in the maternity ward because he was born with a cleft palate:

**I was expressing milk (in the maternity ward)... which I found quite embarrassing ... I felt quite exposed. Everyone – I mean all the other mothers, were just sitting there breastfeeding and I just, really – I started to retreat, even then, and feeling very different**

**from the others... I always thought I was going to be a good mother and I just felt I wasn't a good mother because I couldn't even... feed my child...**

Heidi, like Ilana, speaks of her need to be a "good mother" and that by breastfeeding successfully she could fulfil that expectation of herself. Her failure to do so made her feel that she was not a "good mother". Furthermore, Heidi felt exposed in her failure to breastfeed because she had to express milk in the maternity ward where other mothers "were sitting there breastfeeding". She feels that this was the beginning of her sense of feeling different and of not being a normal, good mother.

While some studies have not found a link between breastfeeding and postpartum mood (Kumar & Robson, 1978; Paykel et al., 1980), others have found that women who breastfeed are more likely to experience postnatal depression (Alder & Bancroft, 1988; Alder & Cox, 1983; Romito, 1988) and that women with postnatal depression had a reduced preference for breastfeeding (Galler, Harrison, Biggs, Ramsey & Forde, 1999). Romito (1988) found that breastfeeding was a difficult experience for many of the mothers in her study because, contrary to their expectations, they were not successful at breastfeeding. The reasons for this failure were twofold. Firstly, it was related to the obstetrical interventions women underwent during delivery such as Caesarean section which made it difficult to hold the baby and find a comfortable position for breastfeeding. Secondly, it related to the lack of knowledge and support from the breastfeeding staff who would differ in their philosophies and methods of breastfeeding. This, in turn, led to confusion and feelings of incompetence about breastfeeding.

In Ilana's case, lack of support and knowledge from maternity staff certainly played a role in her feeling of failure to breastfeed. She was told to try countless ways of breastfeeding including one method where she says:

**I had this tiny bottle of formula... with a little tube that you tape onto your nipple... and the baby sort of sucks your nipple but actually draws the formula out as well... you can't believe the rigmarole... it was absolutely horrific. It changed my whole**

**understanding of breastfeeding and the nature of nurturance...it was very powerful.**

The irony for Ilana, which is true for many of the women in this category, is that, contrary to popular belief, it was only after she stopped breastfeeding that she started to bond with her child because suddenly the whole stress of the breastfeeding was removed from her situation. Ilana says that this realisation for her was,

**so iconoclastic, so significant because I think that there is this misconception that that (breastfeeding) is the only, that that is the most important thing. It's nonsense.**

Other difficulties associated with breastfeeding which were not mentioned by the women in the present study are that breastfeeding mothers are more tired than bottle-feeding mothers because breastfed babies eat more often during the night (Alder & Bancroft, 1988), cry more (Dunn, 1977), and are more colicky (Rubin & Predergast, 1984) than bottle-fed babies. Furthermore, breastfeeders experience less sexual interest and enjoyment because of hormonal factors (lower androgen levels), pain during intercourse, fatigue due to greater sleep disturbance, and/or conflicts in some women between their identities as a sexual person and as a breastfeeding mother (Alder & Bancroft, 1987). Finally, Romito (1988) argues that other aspects going beyond the specific issue of the sexual relationship may be relevant. Breastfeeding mothers share fewer activities with their partners which could result in less closeness between them. There was also greater disappointment on the part of breastfeeding women in their partner's behaviour as the latter participated less in baby-care than they had expected (Romito, 1988).

### ***Sick/colicky baby***

Eight out of the 17 women in this category attributed their postnatal depression to having a demanding or colicky baby. "Demanding" and "colicky" seem to go hand in hand in the childrearing discourse here. According to Heidi:

**He got colic, and he used to scream and scream, and we could never go anywhere because he just used to scream in the car, he used to scream – he just screamed all the time.**

Elaine says:

**Nina had colic... she just screamed and cried and I felt dreadful. I remember at the end of the day the baby was crying, I was crying, and I still didn't recognise it as depression.**

Other women did not label their children with colic but did refer to them as being sick. As Sharon says:

**She used to just puke all over the place all day, so ... I was constantly covered in it and the house was constantly messed in it and you just get ready to do something and then you would have to change both her and you... and at night I was just changing bedding and it was just horrendous.**

Lucy says of her daughter Stephanie:

**She was a sickly, sickly child. She would not go to sleep at night. I used to rock her till like twelve at night, every single night.**

Jessie acknowledges that her child was unhappy:

**He just wasn't a happy child. He was very, very active... the only thing that made him happy was to be carried out. So that's what I think triggered it – because he was so difficult.**

The demands of a crying child felt relentless and tiring for these women. More importantly, however, is that they felt helpless in the face of incessant crying. Many of the women were told by clinic staff that their child had colic. This, it seems, is a label attached to children who cry a lot and are difficult to settle. While some of the



babies may indeed have suffered from colic, it is questionable as to whether it was a definitive diagnosis or whether the babies were unhappy or temperamentally more difficult.

Maternal ratings of infant temperament have been shown to predict postnatal depression (Da Costa et al., 2000; Hopkins et al., 1987), but it is unclear whether a more difficult infant contributes to postpartum depression (Norwood, 1997; Terry et al., 1996) or reflects the mother's mood state (Grazioli & Terry, 2000; Hart, Field & Roitfarb, 1999; Panaccione & Wahler, 1986; Schaughency & Lahey, 1985). Norwood (1997), for example, used independent observers to rate children's behaviour and found their appraisals to be similar to that of the mothers'. In other words, these children were objectively (to the observers) more difficult which means that it was not the mothers' depression which was informing her perceptions of her child as difficult. Other studies have either relied solely on the mother's perception of her child (Edhborg, Seimyr, Lundh & Widstrom, 2000) or used "blind observers" and have found that the children were not, in fact, more difficult than the children of a control group of non-depressed mothers (Hart et al., 1999). Hart et al. (1999) go on to caution that "although perceptions of infants appear to be coloured by maternal depression status as early as the immediate postpartum period and, though "subjective", these perceptions are predictive of infant outcomes." This, they argue, results from negative perceptions predicting a negative self-fulfilling process. As far as sleep is concerned, problems in this area have been found to be more frequent and severe in children of depressed mothers (Jones, Field, Fox, Lundy & Davalos, 1997; Stoleru, Nottelmann, Bellmont & Ronsaville, 1997).

Children, it has been shown, are extremely sensitive to the quality of their interpersonal environment from birth (Field, 2000; Marquette, 1999; Nair & Morrison, 2000). They may react with withdrawal and signs of distress when the mother is perceived as unresponsive or unavailable (Tronick & Weinberg, 1997) or become increasingly more violent in order to elicit a response from his depressed mother (Emanuel, 1999). Thus, the children of the women in this study may have been "difficult" and "fussy" as a result of the mother's mood. Conversely, fussy and demanding children are not easy to soothe (Whiffen & Gotlib, 1989) and may create a

sense of helplessness in the mother or may negatively influence her self-confidence in parenting, thereby triggering depression (Edhborg et al., 2000; Fowles, 1998).

The core problem, regardless of causation, is that the mothers in the present study found that difficult behaviour in their children (be they distressed, demanding, crying) was extremely stressful to manage. This can interact in complex ways with the mother and her self-appraisals of competency in mothering (Teti et al., 1996) and may contribute to postnatal depression (Terry et al., 1996).

### ***Myth of motherhood/unrealistic expectations***

Half of the women from this sample attributed their postnatal depression to unrealistic expectations of motherhood. Expectant mothers are faced with a barrage of expectations and prescriptions about the physical, emotional and social demands of motherhood. These are fostered by folk beliefs, television, newspapers, magazines and “experts” in the fields of sociology, psychology and medicine. The images often portrayed in the mass media of the functional, happy and fulfilled mother are unrealistic and unhelpful because they only reflect some women’s experience some of the time. In fact, the mothering experience does not always match the prevailing ideal of the contented woman, secure in her role, satisfied with the rewarding task of childrearing and comforted by the knowledge that she is doing what only she can do (Antonis, 1981). For Oakley (1980), the idealisation of motherhood and its ramifications is one of the greatest problems facing mothers today.

The myth of motherhood being a blissful, fulfilling, natural experience is so vehemently supported in society that little room is left for women to express their reality of disappointment or difficulty with the experience (Breen, 1975). As Patty says:

**My mom-in-law kept on saying to me ... isn't this the most wonderful time of your life and at times I'd be feeling no, you know it wasn't, I'd feel miserable but I could never say that**

**because I would be worried that people would think that I didn't love my child.**

There is often a disparity between a mother's expectations of "ideal mothering" and the "ideal baby" before giving birth and her experience of herself as a mother and her real baby after childbirth. (Antonis, 1981; Mauthner, 1998b). A number of studies have dealt with the conflict between the expectations and the experience of motherhood (Oakley, 1981; Prendergast & Prout, 1980) and its impact on postnatal depression (Breen, 1975; Gruen, 1990; Lee, 1997; Nicolson, 1988; Oakley, 1981; Warner, Appleby, Whitton & Faragher, 1997). Nine of the women in the present study felt that they had got postnatal depression because they had unrealistic expectations of motherhood.

Wendy expresses this with regards to her baby:

**Nobody can ever tell you what it will really be like ... but now, when somebody says, my child's been niggley, I can feel what niggley is – I can feel that means that you carried that child around the whole day yesterday while you cooked and cleaned and whatever. But... before I couldn't imagine what it would be like. And I think it was a heck of a shock – it was just a heck of a shock that your life is now surrounded, you know focused, on this little ... Hitler.**

She continues:

**The shock of going on holiday and realising it wasn't a holiday because you still got up at the same time in the morning, you couldn't lie and read in bed, you still had to feed at regular times and put her down at the regular times.**

Not only is mothering relentless, it is often done without any acknowledgement. The lack of acknowledgement that comes with the demanding task of being a mother was the trigger for Jessie's postnatal depression:

**I felt really, really lonely... and I just needed to hear that you're doing a great job... you know, I just needed to hear that I was doing a good job, and I didn't 'cos I didn't have that support.**

Carla also needed some form of acknowledgement, but raises the question of what makes a good mother:

**How do you actually assign any kind of worth to being a good mother? There is no barometer of success because no-one has given an award, or no-one is saying to you – you've done well today. You know, what are the measures... How little your child cries? How much your child cries? How well he's eaten? How many nappies it's soiled. It's not called the hardest non-paying job for nothing!**

When ideologies fail to meet expectations not only does it lead to disappointment but anxiety, anger, resentment and lack of confidence are also aroused because one is failing to meet the implied “right way of doing things” (Glenn, Chang & Forcey, 1994). This, Mauthner (1998b) argues, is one of the reasons why women get postnatal depression. In the present study, as in Gair's (1999) research, women's expectations were unrealistic mostly in terms of the demands of motherhood on their time and energy. For example, they did not expect it “to be such hard work” (Fiona); they did not expect to feel such “chronic fatigue” (Ilana) or experience such sleepless nights (Jessie).

Carla admits that she had a “completely romanticised perception” of what it would be like to have a baby:

**I think that part of it (the PND) was that I had planned so much in advance, of the way it was going to be – you know – I'll have this baby, no problem – back to work – two months, carry on, life will be the same, you know and I now just have a family and I have a little girl that I could dress up and you know, she will be my real-**

**life Barbie, because I never had one when I little... And Boy! When it happened, like excuse me, but I'm not supposed to give birth to a baby... where's my four year old that I'm supposed to dress up and... drink tea with the teddy bears with? You know, the reality was completely out – as to what – how I'd ... envisaged it to be, as to how it really was.**

As Jane Price (1988) says, it is not the experience that is aberrant – it's the expectation. The reality, as explained in the feminist literature on the subject, is that women are faced with the increasingly difficult and all-consuming task of raising children in isolation, and the uncertainty, confusion, ambiguity and discontent of mothers' mothering in modern western society (Gair, 1999). When expectations are thwarted, Mauthner (1998b) argues, mothers are faced with a moral issue in which their sense of moral worth is at stake. The only morally "correct" action was to deny their own needs and feelings and try to fit into their preconceived definitions of the "good mother" or the "normal mother"- that being she who puts her baby first (Oakley, 1981) is with her baby 24 hours a day and is continually and actively responding to her baby's needs (Phoenix, Woollett & Lloyd, 1991).

As July says:

**I got depressed because of unrealistic expectations... I think I lost myself in the whole birthing experience, and you know, my whole focus of my life became this little baby that just demanded everything, and ... there was no space for me.**

An interesting finding was that while many of the respondents located feelings of failure to live up to the "ideal image" of motherhood as a cause of their depression, few questioned the validity of the social construction of this ideal. In failing to do so, it is the mothers themselves who perpetuate the myth of an idealised version of motherhood. This is done to prevent anyone from perceiving that she may not be coping.

Amanda highlights the moral dilemma of not coping by talking about the shame associated with it. Furthermore, she upholds the “mask of motherhood” (Maushart, 1997) by hiding her true feelings of the experience of motherhood:

**What else made it [the PND] worse, was the shame associated with it. That – how much I had to show the world I was functioning okay, and not share my truth, that I was dying. And show my husband that I was still functioning well, that he didn’t make a mistake in marrying me, that he still had a wife.**

Amanda, like other mothers, found herself faking “happy motherhood” for fear of being perceived as a failure or as a “bad mother”. As Mauthner (1999) found in her study, the women “feared burdening their partners, and being misunderstood, rejected and morally condemned” (p. 155). By withholding their true feelings and needs at this vulnerable point in their lives, women are effectively isolating themselves from potentially supportive relationships and environments. This, for Mauthner (1999) is the key to postnatal depression. She states that “postpartum depression occurs when women are unable to experience, express and validate their feelings and needs within supportive, accepting and non-judgmental interpersonal relationships and cultural contexts” (p. 143).

The reality of motherhood is an experience rich in complexity and difficulties and mothers are often filled with feelings of ambivalence, loss and resentment about their new role. There is a distinct “gap” in the available discourses around negative experiences as a normal part of motherhood (Lewis & Nicolson, 1998) and this, Maushart (1997) argues, may be experienced as a personal crisis but is ultimately a social tragedy. Just as the traditional version or rhetoric of motherhood is so prevalent so too must the true experience of motherhood find its place in the discourse on motherhood. This can be done by not only listening to what mothers have to say but also, more importantly, taking them seriously. Furthermore, antenatal classes need to present a picture more true to the realities and concrete experiences of mothers (Lee, 1997). Finally, a context needs to be created in which the range of feelings of mothers, from negative to positive, is accepted and acceptable (Mauthner, 1998C).

### *Sleep issues*

In this study half of the women associated their postnatal depression with issues relating to sleep. For some this was about the exhaustion they continually experienced and for others it was about their anxiety about not being able to sleep or not getting enough sleep.

As Sharon explains:

**Lack of sleep was a real issue, it wasn't that I couldn't sleep it was just that you kept getting disturbed. It was that desperate, desperate feeling of never, never getting a proper night's sleep – never getting a long enough stretch – and just being utterly exhausted all the time.**

Mothers are frequently disturbed throughout the night by a crying baby or a niggly baby which would require them to get up and attend to whatever it is the baby is needing (a feed, nappy change, warm blanket etc). Lack of sleep accumulates insidiously and once acknowledged can become a major focus of obsessive thoughts.

This is reflected by Betty:

**I don't think I realised how tired I was... I was so exhausted ... it was horrific... I thought I've got to sleep, I've got to sleep... and I panicked. I've always had a bit of a thing ... to do with sleep. I've always been an 8-hour a night person... I've always been quite obsessed with my sleep which is not the thing to have when you've got twins.**

Fiona elaborates on the sleep issue:

**I couldn't sleep – couldn't sleep. I slept but I didn't sleep well. I was absolutely exhausted – that was when the depression came in.**

Another woman in the study described her sleep deprivation as “physically and mentally shattering”. Many of the women spoke about their difficulty of not being able to fall asleep once woken up for a feed or simply a crying baby.

According to Jessie:

**It didn't matter if I was only up for ten minutes or if I was up for two hours – I couldn't get back to sleep.**

Amanda is a medical doctor and she describes her experience as follows:

**I've always been anxious about my sleep since my house job, and I knew I needed sleep at night...I was terrified of being up at night because then I'd get exhausted and when I get exhausted I get depressed... I just wouldn't cope. The anticipation of being up at night is hell. When I wasn't sleeping at night it just caused this cycle of hell... going round and round in that utter hell.**

Prolonged sleep deprivation is epidemic among mothers of young children and is a significant factor in their postnatal adjustment (Hopkins et al., 1989). Yet of all the many studies investigating the variables associated with postnatal depression, sleep deprivation is barely mentioned (Gair, 1999). When it is mentioned it is predominantly with reference to children's sleeping patterns and behaviours. In particular, researchers have focused on the effect of a mother's depressed mood on the sleeping patterns of children. Studies have shown that children of affectively ill mothers had more frequent and severe sleep problems (Stoleru et al., 1997) or less predictable sleep patterns (Jones et al., 1997). The women in the present study felt extremely sleep deprived i.e., had less sleep than they were used to and this was not necessarily mirrored in their children's sleep patterns. In other words, even when their children were sleeping they were unable to sleep mainly due to high levels of anxiety. They spoke about sleep deprivation as a major cause of their depression and how it contributed to their inability to cope with their babies.



### ***Work issues***

Work issues related to the stress of working in a paid job or not being employed at all and missing work or feeling isolated as a result of not working. It also included women who grappled with the concept of being at home with their babies versus working in their professions. Altogether 13 women mentioned work-related issues as one of the causes of their postnatal depression.

Many of the women who did not return to their work after giving birth felt isolated and lonely at home. They missed the social contact that they had enjoyed previously with their colleagues at work. In addition to this, many of the women felt that in the absence of work they lacked affirmation, acknowledgement and self-esteem which they had always derived from their employment.

Patty illustrates this:

**I think work has always been kind of a big sort of feature in my life and I've always kind of felt useless if I'm not working and also being isolated from adult company... I found that very lonely... I didn't make many new friends with children because I found it kind of tiring to only speak about babies... and what make of nappies you are using.**

Ilana also felt that without her work it was difficult to feel good about herself:

**I had to learn all over again to validate myself when I was just a person... it was nothing to do with my skills, or the authority the company had given me ... it was just little me and I had to feel that I was worth something... without any status conferred on me or any resources conferred on me either.**

Elaine echoes this sentiment:

**I was a person who had always defined myself in terms of what I'd achieved... at the end of the day, what have I actually achieved now... I've done nothing, all I've done is breastfed this baby and there's nothing to show for it... she's still screaming and crying.**

What becomes evident from the perceptions expressed by these women is how undervalued the all-encompassing job of motherhood is. Without the occupational rewards of financial income, affirmation and casual interaction with colleagues, these women felt worthless. They felt that their investment in their children bore few, if any, rewards ("all I've done is breastfed this baby and there's nothing to show for it... she's still screaming and crying"). Again, it seems, their expectations were not met. Perhaps they expected childrearing to be as gratifying as their work or perhaps they expected to reap immediate rewards from it.

Social scientific studies, and feminist studies in particular, theorise postpartum depression as a "normal" response to motherhood which is linked to "public-world" losses of, inter alia, power, autonomy and paid employment (Mauthner, 1999; Nicolson, 1999). Traditional views of gender roles, combined with the empirical evidence that women are more prone to mental health problems than men (Klein, Shibley Hyde, Essex & Clark, 1998), has led researchers to assume that the addition of employment to "women's roles" as wives and/or mothers would be particularly stressful (Barnett, Marshall, Raudenbush & Brennan, 1993; Glass & Fujimoto, 1994). A number of studies have found that employment is associated with positive mental health among women (Barnett & Baruch, 1985; Repetti & Crosby, 1984), less depression (Glass & Fujimoto, 1994; Kessler & McRae, 1982), less anxiety (Kessler & McRae, 1982; Voydanoff & Donnelly, 1989) and greater self-esteem (Kessler & McRae, 1982; Klein et al., 1998). Kandel, Davies and Raveis (1985) report that mental health is even better among employed mothers compared to unemployed mothers.

Klein et al. (1998) explain this in terms of the "enhancement hypothesis" which argues that women's lives are enhanced by the potential of the workplace to afford them greater economic power, more social contact or support, rewarding working conditions and family support. Nicolson (1999) supports this argument, saying that

the workplace provides a forum for intellectual challenges, informal contact with other people, money for the family unit, economic power and autonomy.

Lucy's employment was terminated after she gave birth and this, for her, was a major contributing factor to her postnatal depression. She explains the effect of that:

**It (the termination of her job) was the worst possible time because ... to me... it was like I'm worthless. I didn't know what to do with myself... it's a complete rejection because also it (work) became quite a social thing for me... people that I saw on a continuous basis ... I felt cut off from that completely... there was nowhere to go, nothing to do and that... freaked me out completely.**

One of the key factors associated with employment among mothers is that of the degree of congruence or fit between attitudes toward employment and employment status. For example, Hock & DeMeis (1990) found that depression was highest among women who preferred employment but for one reason or another had chosen to stay at home. Pistrang (1984), in his study with first-time mothers, found that women who had been highly involved in work prior to motherhood but chose to stay at home after having a child exhibited the highest levels of depression and irritability and the lowest levels of self-esteem. Lucy, in this study, was retrenched from her job shortly after giving birth and although she had always planned on returning to work, she was now forced to stay at home to look after her baby:

**I'm not a very domesticated person... I wish I was... but I'm not at all like that. It's like I had all this energy that there was no outlet for... I had to stay at home with this baby, who I didn't want to be with, I hadn't planned for it... So I think it was just ... the very intense feeling of rejection, of not having anywhere to go or anyone to talk to.... Because whatever I did was home-based.**

Carla's story portrays this dilemma of career woman versus home mother:

I had to go back to work when she was 8 weeks old and the anxiety started in terms of the separation – of me having to leave her at home with the nanny – that I wasn't with her and the guilt involved that I've just had this baby, and I basically palmed her off onto somebody else to bring up. I found it extremely difficult to balance being a mother, a career person and a wife, and there was the me that didn't come into it at all. The failure associated to ... being a mother... I had a child and then spent the whole day at work – you know- failed as a mother but... I wasn't even succeeding as a career person because my anxiety was draining every aspect of it, and I couldn't really focus on my workload.

When her anxiety levels became intolerable, Carla resigned from her job so that she could raise her baby herself:

I was angry with the fact that, as a woman, I was put into a situation that I had to choose between being a professional person as well as being a mother, and not being able to cope with the two on an equal par... I basically went from being a total career-driven person to a person ... who stayed at home and claimed unemployment. And then from that scenario... came more guilt, more anxiety that I was now dropping out of my career path and there was a feeling of ... resentment ... that this whole thing had basically ruined my life. I was now not only an anxious person, I was now an unemployed anxious person, which made it worse.

Loss of occupational identity, as in Nicolson's (1999) study, was experienced as a loss of who they had been before the baby was born - be it an ambitious career woman, a professional, financially self-sufficient, worthwhile and valuable or part of the living, real world. The loss of social contact and the loss of self-worth that results from mothering a baby in the confines of one's home cannot be underestimated. Not only do women need to be acknowledged and rewarded for their mothering job, but institutions also need to be set in place where mothers are integrated into the larger

society as a valuable entities. If women do chose to work, work policies and benefits that provide flexibility for employed mothers in addition to work-related support systems seem to be crucial (Gjerdingen & Chaloner, 1994b).

## **Biological Factors**

### **Predisposition**

Many women felt that they were predisposed to suffering from postnatal depression either because they had a personal history of depression themselves (10 women) or because there was a history of depression in their family (7 women). In addition to this, the category of predisposition includes those women who attributed their depression to hormonal or biochemical conditions resulting from pregnancy and childbirth (7 women). Altogether 14 women felt that they got postnatal depression because of these reasons.

### ***Hormonal/biochemical causation***

Betty attributed her postnatal depression, in part, to hormonal factors:

**I just wonder about the hormone cocktail that was in my body because I had fertility treatment, hormonal treatment for two and a half years, then at 32 weeks I went into prem labour... and I was on Ipradol for 3 weeks. Every weekend I'd have steroids... and then I went onto Eglonyl ... another thing as well is that I had a thyroid complaint many years before and so they tested my thyroid and ... nothing was going on. I was hoping it was actually my thyroid, and I'm not completely convinced that there wasn't an element of that in it... I like to think that it (the PND) was simply hormonal or biochemical ... because the other reasons to me don't make as much sense.**

Of more relevance to the present study is why participants, such as Betty, actually expressed a hope that the origins of their depression were rooted in the biochemical arena. Whether on a conscious or unconscious level, a number of women felt that such a biomedical diagnosis would absolve themselves of blame for the hardship they were causing themselves and their families. It would also make it easier for them to understand their condition while at the same time not owning responsibility of causation for it. Aetiology is closely linked to treatment and by obtaining a biomedical diagnosis for their depression they could take medication to “cure” it and not have to work through often difficult and buried psychological issues which is far more demanding and frightening than taking a pill. The message received from most of these women, however, pointed to the need for a biomedical diagnosis in order for their suffering to be taken seriously by those around them. For them, their postnatal depression would be seen as legitimate or credible if they could show or tell people exactly what the cause of it was, for example, a thyroid disorder.

This is highlighted by Carla:

**The psychiatrist ... immediately sent me for tests to check my thyroid, my hormonal balance. And the fact that it was normal was a great disappointment, because you know... there's one thing having a ... psychological problem, and it only having psychological associations, it kind of almost lessens the impact if there's no medical, factual association attached to that. And for me, if I – I know it sounds so hard, but if I could have walked away from that pathology lab and then have it said to me: My girl, you've got a hormonal imbalance, I think it would have been the absolute rescue remedy for me. That there was a total factual, intellectual, medical attachment associated to ... this postnatal thing.**

While the “sick” label may be helpful for some women, some researchers argue that such a label is inappropriate and even detrimental to mothers because it ignores the reality of motherhood with its massive workload, loss of uninterrupted sleep and

overwhelming responsibility (Cox, 1986; Gair, 1999; Mauthner, 1993; Nicolson, 1986; Oakley, 1984).

The biological basis for postnatal depression cannot, however, be ignored and a plethora of studies have investigated a possible hormonal or biological cause for postnatal depression. As noted previously, researchers have studied the role of several substances and their impact on postnatal depression such as estrogen and progesterone (Dalton, 1971), prolactin, (Nott, Franklin & Armitage, 1976), corticosteroids and tryptophan (Handley et al., 1980), norepinephrine (Treadway, Kane, Jarrahi-Zadeh & Lipton, 1969), serum prollyl endopeptidase (PEP) (Maes et al., 2000), corticotropin-releasing hormone (Schmeelk, Granger, Susman & Chrousos, 1999), pterins (Abou-Saleh, Ghubash, Karim, Krymski & Anderson, 1999), oestradiol (Ahokas, Kuakoranta & Aito, 1999) and thyroid (Harris et al., 1989; Harris et al., 1992). While postpartum hormonal changes may impact on women's moods, a biological basis to postnatal depression has not been established (Cooper & Murray, 1998; Nicolson, 1999; Nott et al., 1976; Richards, 1990; Romito, 1990). Furthermore, if postpartum depression is induced by hormonal or endocrinological changes, why is it that many women do not get depressed following childbirth? Finally, postnatal depression has been reported in adoptive mothers (Gair, 1999; Melges, 1968; Van Putten & La Wall, 1981) as well as fathers (Areias et al., 1996; Atkinson & Rickel, 1984; Hagen, 1999; Meighan et al., 1999; Soliday et al., 1999) which renders nil the biological influence of childbirth on postnatal depression.

### ***Personal/family history***

Half of the women in this sample felt that they were predisposed to postnatal depression because they had experienced depression at a previous time in their lives. Sharon, for example, says:

***I had experienced depression before – it was something I was familiar with.***

In Vanessa's experience:

**I was in therapy already and had a history of depression, so I had been wondering if I would get it (PND) but I didn't expect to get it like that.**

Debby states her personal history:

**I always suffered from depression... you can't really say which one was the main contributing factor but maybe... just my depression because ... I was trying to commit suicide when I was twenty or something and again – well 19 and then 21 and I was in nursing homes as well on 2 occasions and in therapy for years.**

For some of the women it seems that their postnatal depression was another episode of clinical depression in their lives. A number of studies have investigated the relationship between postnatal depression and previous episodes of depression. Results have been contradictory with some studies finding a significant link (Cooper & Murray, 1995; Hapgood, Elkind & Wright, 1988; Meltzer & Kumar, 1985) while others not (Maes et al., 2000; Mills et al., 1995).

Seven of the women spoke about depression in their family members, be it parents or siblings, and how that predisposed them to postnatal depression.

Elaine's father had suffered from depression and she feels she inherited that tendency from him. When asked why she got postnatal depression she immediately answered:

**A history of depression. So I think I had an inclination towards being depressed. I mean there's a history of depression in my family. My father committed suicide when I was 16 and I think I did inherit that tendency from him. If I look back now and think, as a teenager I suffered from depression but it just went undiagnosed and untreated.**



Amanda also felt she was genetically predisposed to depression. Again her immediate response to the question as to why she got postnatal depression reflects this:

**I think number one is that I am genetically predisposed. My mother suffered from depression... my twin sister had severe postpartum depression with both her children, I'd been depressed before in my house job and I knew I was prone to it. I mean I think I was genetically predisposed, biochemically predisposed... my serotonin levels aren't good... don't carry me through stress.**

It is interesting that for both Elaine and Amanda "predisposition" was their immediate response to the cause of their postnatal depression. Perhaps for both of these women it is the most simple and clear explanation for their experience. In addition to this, for many women in this study it was the cause most frequently alluded to by their doctors. More important than this, however, is that, as mentioned above, it was the cause most people felt most comfortable with, be they family members, the medical fraternity or the women themselves.

Nevertheless, with regard to a family history of depression and postnatal depression some evidence points to a link between women whose siblings or parents have suffered from a depression and postnatal depression (Meltzer & Kumar, 1985; Mills et al., 1995; Nilsson & Almgren, 1970; Reich & Winokur, 1970; Treloar, Martin, Bucholz, Madden & Heath, 1999).

The category of "predisposition" is a very powerful one for those women who felt that no matter what, they would have got postnatal depression. Whether due to their innate nature or an endogenous condition, postnatal depression was utterly inevitable for them and unavoidable.

Carla and Amanda express this in similar ways. Carla says:

**I think you're either predisposed for that kind of ... emotional state or aren't. You know, if I had to take away all of those things, If I had to say that I hadn't had any traumatic life experience... If we**

**were both earning loads of money at the time, ...you know if none of those extraneous things were there at the time, I probably still would have suffered from it, just from the point of view that it's my nature.**

Amanda reiterates this:

**I had been through a divorce; I had been through a new marriage; I had even lost a child when he was eight days old.... All the losses I've described – you know there was a lot of life stresses. And yet, if I had none of those life stresses, would I have got it? Yes! My husband kept on saying to me – You pre-empted this, you created it. I said, Jeess – if I had any control over this burning up feeling it wouldn't be there. My body did it. It was a body experience.**

For some women it seems that there is the perception that their postnatal depression is rooted in a “purely” biological cause. The stressful life events that existed during their postnatal period were seen to exacerbate their depression but the specific cause of their depression was biological in nature and thus seen to be unavoidable. Kleiman and Raskin (1994) support this argument. They say that women who have what seems to be a “pure” biological disease present with strong biological symptoms such as insomnia, weight loss, extreme fatigue, profound difficulty getting out of bed in the morning, inability to function even minimally and/or hallucinations.

Postnatal depression, according to the perceptions of the women in this study, is caused by a range of different factors. On the one end of the spectrum are those women for whom the biological cause is most obvious. For other women, massive stress and poor support structures seem to be the cause. Still for others the cause lies in events from their past which have left them vulnerable to depression during this major life transition. For some of the women, their postnatal depression has elements of each one of these causes.

What follows is the concluding chapter, which consolidates the perceptions of the women in this study with regard to the aetiology of postnatal depression.

## CHAPTER SIX

### CONCLUSION

The aim of this research project was to explore how women who had recovered from postnatal depression explained their condition. A women-centred qualitative approach was adopted which allowed for the participants to express their thoughts freely without being restricted by preconceived theories in this field. This contrasted from the traditional medical model which makes use of quantitative methods of investigation and tends to restrict responses to what the researcher assumes to be related to the aetiology of postnatal depression. The qualitative nature of this research, with the use of open-ended questions, facilitated interesting, rich and meaningful insights into postnatal depression. The women in this study were given the opportunity to appraise their experience of postnatal depression in their own words and on their own terms. By allowing women the freedom to construct their own thoughts on the causes of their postnatal depression, neither they nor the researcher were restricted by existing research “wisdoms” in the field of postnatal depression and its aetiology.

It is important to note that the aim of this study was to explore women’s understanding of the causes of postnatal depression. Investigating their *perceptions* of cause was of primary importance to the researcher. The intention was not to make any truth claims on the *actual* cause of their postnatal depression. Hence, the findings are not purported to be definitive aetiological explanations; rather they shed light on how woman understand the development of postnatal depression for themselves.

The cause of a condition such as postnatal depression is generally multi-faceted, particularly when there is not a clear biological basis. However, little attention has been paid to lay perspectives in this field. From a feminist perspective, it is believed that greater attention to lay perspectives may improve the quality of research. This argument is based on the fact that lay views often differ from those of health professionals and researchers. Furthermore, the lay perspective has legitimacy, can add value and may highlight areas which could have been overlooked by the

researcher (Entwistle, Renrew, Yearley, Forrester & Lamont, 1998). This thesis thus attempts to lend credibility to women's insights – their perceptions are by no means presented as *actual* causes of postnatal depression but it is argued that it is they who suffer from postnatal depression and their contribution to understanding the causes of postnatal depression cannot be ignored.

Participants' discourses about postnatal depression suggested that their understanding of the condition and their attributions of cause traverse the boundaries of the common models and perspectives on postnatal depression. The deterministic notion of postnatal depression being caused by a single biological phenomenon, as expounded by the medical model, was not sustained here. The women in this study expressed multiple causes for their postnatal depression. Not only did each woman express a number of causes for her postnatal depression, but they also differed markedly from one another in terms of their attributions. This study thus highlights the variable perceptions of women. Each woman's reality is informed by her individual circumstances and her collection of expectations about motherhood. To present a unitary coherent picture of explanations for postnatal depression would not do justice to this variability in experience which informs each woman's perceptions.

The perceptions of the women in this study reflect the contention that no single aetiological model, be it the biological, psychological or interpersonal model, is adequate in explaining the causes of postnatal depression. The women's explanations for postnatal depression were multilayered and point to a complex interplay of biological and psychosocial factors. Their understanding of postnatal depression was more reflective of the feminist position. This position takes into account the impact of the prevailing ideology on motherhood which idealises the experience and creates unrealistic expectations for most mothers (Wolf, 2001). By giving the women in this study a chance to talk about their perceptions of cause, many of them expressed relief at being allowed to traverse the boundaries of the idealistic picture of blissful motherhood. They welcomed the opportunity to speak frankly about topics that are often considered taboo, such as relationship issues, difficulties relating to mothering their infants and the experience of loss that was significant for many of them.

It is impossible to simplify the findings of this study and reduce the perceived aetiology of postnatal depression to one or another cause. Rather, the point needs to be emphasised that, according to the women's perceptions in this research, postnatal depression results from a myriad of inter-related factors which interact with one another in different ways to produce a largely different picture for each and every woman.

What this thesis does show, nevertheless, is a number of pervasive themes that were familiar to most of the women's experiences of postnatal depression. What follows is a comparison between the participants' perceptions and existing aetiological models of postnatal depression.

Many of them believed that their postnatal depression had a strong biological component which was beyond their control – they felt predisposed to postnatal depression either because of an endogenous biochemical imbalance or because of a personal or familial history of depression. Unlike the traditional medical model of depression which emphasises the technical and clinical aspects of a biological depression following childbirth, the findings of this study went one step further in that they point to the implications of a medical explanation for women. By attributing their postnatal depression to a physical cause the women felt that they would be taken more seriously (i.e., they were not fabricating this) and they would not be blamed for their unhappiness at this supposedly happy time in their lives. Clearly the biomedical model is an essential component of any aetiological explanation of postnatal depression but, according to the results of this study, it was important to understand *why* the medical model was so important for women and that it certainly was not the only explanation for their postnatal depression.

The theory that interpersonal factors are associated with postnatal depression was mirrored in the explanations presented by the participants in this study. The significance of a supportive environment on both an emotional and physical level, be it from one's partner, one's family or one's broader social system, cannot be underestimated. Of particular importance in this study, as well as many others, is the new mother's relationship with her partner and with her own mother and how this contributed to the development of postnatal depression.

The general experience of women in this study was that of disappointment in their partner's inability to support them emotionally and practically. An interesting insight which was raised by the women was their realisation of the extent to which their lives had changed since the birth of their baby and the extent to which their partner's lives had not. This generated feelings of resentment towards their partners which they felt contributed to their postnatal depression.

As far as their own mothers were concerned, the impact of their infant and childhood relationship with them was extremely significant in the development of their postnatal depression. Having a baby raised feelings of abandonment, lack of caring and nurturing from their mothers and general disappointment in their expectations of their mothers as mothers and/or grandmothers. It is interesting to note that the women in this study were disappointed not only in their own mothers as mothers but also in themselves as mothers. Mothers, it seems from this study, continually fail to make the mark of good mothering. Perhaps this perception is particular to women who suffer from postnatal depression. In other words, they become depressed because of their unrealistic expectations of motherhood. This was true for many of the women in this study but further research would be needed to clarify the differing perceptions of depressed and non-depressed mothers with regard to their own mothers perceived "success" in mothering.

The literature on the psychological factors associated with postnatal depression focuses on personality factors and psychodynamic issues. The perceptions of the women in this study confirm the contentions relating to personality factors, in particular with regard to the need for control. The desire for control seems to be rooted in a need for things to maintain a predictable and orderly pattern. Unanticipated experiences, such as the endless demands of having a baby, contribute to a sense of lack of control which can trigger depression in new mothers.

The psychodynamic perspective, which focuses on the new mother's difficulty in assuming the maternal role, is also supported by the perceptions of the women in this study. Although this is a psychological issue, it was dealt with under the category of

“Motherhood” because, for the participants of this study, it was regarded as a cause of depression that was specifically related to being a mother.

Other psychological issues which were of importance to the women in this study revolved around unresolved trauma and loss. The impact of unresolved issues on the emotional well-being of mothers, such as the parenting one received as a child or childhood sexual abuse, has only recently been examined and even then, only by feminist authors (Nair & Morrison, 2000; Tracey, 2000). The results of this study point to the significance of processing difficult aspects of one’s past because of the phenomenon of childbirth bringing to the surface issues and experiences which have not yet been worked through on a psychological level.

The sense of loss that is very common to new mothers is also relatively new in the research on the aetiology of postnatal depression and is exclusive to the feminist perspective. The feminist argument, as reflected in this study, points to the impact of losing one’s sense of identity and one’s previous lifestyle once a baby comes into a woman’s life. As mentioned before, from a feminist perspective the experience of loss and its negative impact on emotional well-being is theorised as a normal response to motherhood, rather than the exception.

The diathesis stress model of postnatal depression, which emphasises the effects of additional stressors on the already vulnerable position of motherhood, is not new to the field and is supported by the findings of this research. A number of women attributed their depression to extraneous stressors such as financial stress and problems in their broader family network.

The most common and comprehensive aetiological theme that emerged from this project was issues related to motherhood itself. This included issues around pregnancy, childbirth, the day-to-day responsibilities of mothers (e.g., breastfeeding), lack of sleep and dilemmas about either working or not working in a paid job as a result of having a baby. The discussion chapter highlighted the depths of these difficulties. At the core of this theme lay the acknowledgement, once again, that for most of the women motherhood was not what they had expected. This failure to meet their expectations was a major contributing factor to their postnatal depression. It

seemed to elicit deep feelings of disappointment in themselves as mothers and in the fantasy that they had always held about motherhood in general.

The women in this study, however, did not question the basis of their beliefs about motherhood – their yardstick for measuring their own competence and fulfilment in the mothering role was not altered by their disappointed expectations. Rather they experienced themselves as failures as mothers. In other words they did not doubt that the cultural myths about motherhood being, for example, satisfying, fulfilling and rewarding were true and reflective of reality. Instead, they believed that their performance as mothers and their experience of motherhood was aberrant – they had failed to live up to the “genuine” and “true” picture of motherhood that women with babies “should” and do experience.

In reality this belief system about blissful motherhood is at least exaggerated and at most false. Time and time again feminist authors and researchers attempt to dispel the myths around motherhood which have been generated by decades of “scientific” research, popular media representations of motherhood and even women themselves who feel obliged to conform to the cultural “norms” of motherhood (Kleiman & Raskin, 1994; Lerner, 1998; Maushart, 1997; Mauthner, 1998a, 1998b, 1999; Milgrom et al., 1999; Wolf, 2001).

Traditional causal models of postnatal depression do allude to pregnancy and the birth experience as having an impact on postnatal depression. What is undermined or ignored by research in this field, however, is the extent to which mothers’ lives are altered by the birth of a baby and the extent of the negative effects of this on their emotional state of mind. Whether it is the sleepless nights, the breastfeeding, the seemingly endless demands of a baby, the isolation, the lack of acknowledgement or the loss of an income, the very foundation on which her life was previously based was, for many of the women in this study, immeasurably and unexpectedly transformed. As Maushart (1997) says, the fears, frustrations and confusions of early motherhood associated with the realities of contemporary mothering (from pregnancy and childbirth, to juggling significant relationships with “working motherhood”) are not indicative of personal failure, but of a host of unworkable structures, extravagant expectations and conflicting demands. To attribute unhappiness following childbirth



to biological/hormonal explanations or personality factors is to ignore the highly complex social and psychological factors which interact with the physical in affecting mothers' moods.

In summary, according to the views of the women in this study, postnatal depression is perceived to be caused by a number of factors. Causal attributions differ for each woman according to her history, her situation at the time of giving birth and her expectations about motherhood in general. Some of the women felt that due to a biological predisposition they were inevitably susceptible to postnatal depression and although there were other factors which may have contributed to their distress, the ultimate cause for them was endogenous. For other women in this study the root of their postnatal depression lay in three key areas: their interpersonal situation, their psychological situation and their experience of motherhood. At the core of all of these factors was a profound difficulty in accepting the reality of their changed lives. The women had expected motherhood to be different. They had not expected so little support and so much conflict with the significant people in their lives; they had not expected to feel a grave sense of loss of who they were before having a child and of what their lives had been - they had not expected childbirth and full-time mothering to be so challenging. Their thwarted expectations, in the final analysis, contributed most significantly to their postnatal depression.

The aetiological perceptions expressed by the women were not entirely unique. Traditional causal models of postnatal depression do include biological, interpersonal and psychological explanations. However, what was different about the findings of this research was that unlike the traditional models, no single aetiological factor could account for their depression after childbirth. In other words, none of the women could attribute their depression to, for example, biological or interpersonal factors alone. Their attributions were interlinked and multidimensional. Furthermore, the depth of their explanations seemed to go further than many of the explanations derived from quantitative studies in the literature on postnatal depression. Their causal accounts were enhanced by their own insights, and the meaning they attached to those insights, so that the whole picture that was painted was multilayered and complex.

## LIMITATIONS OF STUDY

Drawbacks of this study centred on the sample of women selected for this research. In the first place, only 20 women participated in the study and although with qualitative research the goal is not necessarily to be able to generalise the findings, the extent to which this sample is representative of women from similar contexts is limited. More important than this, however, is the limited extent to which results from this research could be applied to diverse populations. This sample of women was, for the most part, highly educated and privileged relative to the majority of women in South Africa. Hence, their experience of postnatal depression was not compounded by otherwise relevant variables such as housing difficulties and unemployment (McIntosh, 1993).

Furthermore, this sample consisted of women, or friends of women, who had previously attended a support group for postnatal depression. The content of their explanations for postnatal depression could thus have been strongly informed by the group facilitators and the members of the group itself. However, it was the researcher's opinion that because they had all been out of the group for some time and had all recovered from their experience, their insights and perceptions of cause were largely self-informed and individualistic.

The final drawback of this research lies in the power of myself as the researcher. As Seibold, Richards & Simon (1994), say, "power can be with the interviewee during the making of the data, it is the interviewer/ researcher who has power of analysis afterwards" (p. 396). Although the analysis was discussed at length with the researcher's supervisor and other people working in the field, the researcher's interpretations were essentially subjective in nature. According to Krefting (1991), the task of the researcher is to represent the multiple realities of participants as adequately as possible. Naturally every effort has been made to represent and reflect the findings of this study in an accurate and honest way. It is hoped that the views which have been interpreted and presented in this research project are as accurate as the women who participated in this research project would have wished.

## CONTRIBUTIONS OF STUDY

In spite of the limitations, the study is important in a number of ways. Firstly, postpartum depression is the subject of a plethora of quantitative studies which seek to quantify and tabulate risk factors and variables associated with postnatal depression. This study, being qualitative in nature, pays primary attention to women's accounts of their subjective experience thus providing a credible space for their voices to be heard. The opinions of medical and psychological practitioners in the field are all too often based on those quantitative studies which present superficial facts about postnatal depression. By attending closely to women's perceptions of postnatal depression, this research provides depth and meaning to those superficial accounts and, in addition to this, the findings are grounded in the real-life experience of women who have actually suffered from postnatal depression.

What was striking for me, on a personal level, was the depth of insight women displayed about their understanding of postnatal depression. As mentioned above, this may have resulted from the sample of women selected for this study. Be that as it may, they spoke with tremendous clarity about their struggles around their depression and expressed knowledge and wisdom about their perceptions on it.

This is also the first study of its kind to be done in South Africa and thus is particularly relevant to the local experience of postnatal depression. By disseminating the findings of this project, it is hoped that a broader understanding of the field will be made available to both the women of South Africa and their healthcare workers. It will also hopefully encourage further research within the qualitative paradigm.

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## APPENDICES

### APPENDIX 1

#### OPEN-ENDED INTERVIEW

1. Tell me about your experience of PND  
How did you realise you had PND?  
What did you do about it?
2. There are many reasons why people get PND, why do you think you got it?
3. Do you think there is anything else that may have contributed?
4. How did you come to decide that these were the reasons why you got PND?
5. Do you think you have recovered from PND?  
What are the factors that contributed to your recovery?
6. What do you think was the least helpful advice you were given about PND  
and why?
7. Do you think anything could have prevented you from getting PND?
8. Do you think the experience of PND has changed you and how?
9. What were the most helpful insights that you gained having experienced  
PND?
10. Is there anything else you would like to mention?

## APPENDIX 2

### EDINBURGH POSTNATAL DEPRESSION SCALE

#### EDINBURGH POSTNATAL DEPRESSION SCALE

J.L. Cox, J.M. Holden, R. Sagovsky, 1987 (Adapted by Liz Mills, for use during pregnancy)

Name:

Address:

Phone:

Week of pregnancy:

Date:

As you are expecting a baby, we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

In the past 7 days:

- |      |                                                            |     |
|------|------------------------------------------------------------|-----|
| 1.   | I have been able to laugh and see the funny side of things |     |
|      | As much as I always could                                  | [0] |
|      | Not quite so much now                                      | [1] |
|      | Definitely not so much now                                 | [2] |
|      | Not at all                                                 | [3] |
| 2.   | I have looked forward to things                            |     |
|      | As much as I ever did                                      | [0] |
|      | Rather less than I used to                                 | [1] |
|      | Definitely less than I used to                             | [2] |
|      | Hardly at all                                              | [3] |
| *3.  | I have blamed myself unnecessarily when things went wrong  |     |
|      | Yes most of the time                                       | [3] |
|      | Yes, some of the time                                      | [2] |
|      | Not very often                                             | [1] |
|      | No, never                                                  | [0] |
| 4.   | I have been anxious or worried for no very good reason     |     |
|      | No, not at all                                             | [0] |
|      | Hardly ever                                                | [1] |
|      | Yes, sometimes                                             | [2] |
|      | Yes, very often                                            | [3] |
| *5.  | I have felt scared or panicky for no very good reason      |     |
|      | Yes, quite a lot                                           | [3] |
|      | Yes, sometimes                                             | [2] |
|      | No, not much                                               | [1] |
|      | No, not at all                                             | [0] |
| *6.  | Things have been getting on top of me                      |     |
|      | Yes, most of the time I have not been able to cope at all  | [3] |
|      | Yes, sometimes I haven't been coping as well as usual      | [2] |
|      | No, most of the time I have coped quite well               | [1] |
|      | No, I have been coping as well as ever                     | [0] |
| *7.  | I have been so unhappy that I have had difficulty sleeping |     |
|      | Yes, most of the time                                      | [3] |
|      | Yes, sometimes                                             | [2] |
|      | Not very often                                             | [1] |
|      | No, not at all                                             | [0] |
| *8.  | I have felt sad or miserable                               |     |
|      | Yes, most of the time                                      | [3] |
|      | Yes, quite often                                           | [2] |
|      | Not very often                                             | [1] |
|      | No, not at all                                             | [0] |
| *9.  | I have been so unhappy that I have been crying             |     |
|      | Yes, most of the time                                      | [3] |
|      | Yes, quite often                                           | [2] |
|      | Only occasionally                                          | [1] |
|      | No, never                                                  | [0] |
| *10. | The thought of harming myself has occurred to me           |     |
|      | Yes, quite often                                           | [3] |
|      | Sometimes                                                  | [2] |
|      | Hardly ever                                                | [1] |
|      | Never                                                      | [0] |

Score 0, 1, 2, and 3

\* Score 3, 2, 1, and 0

Cut off: 12/13

SCORE: .....

## APPENDIX 3

### THEMES AND CATEGORIES

**1. Lack of support**

Lack of support  
Coping on my own

**2. Relationship with Partner**

Resentful of partner  
Marital relationship conflict  
No time for self  
Dependency issues  
Affair

**3. Relationship with Own Mother**

Own mother

**4. Unresolved Trauma**

Unresolved childhood issues  
Brutal car accident  
Miscarriage  
Unresolved trauma  
Parental issues  
Abuse

**5. Loss**

Loss  
Loss of a child  
Loss of freedom  
Loss of identity  
Loss of self-esteem

**6. Pregnancy**

Ectopic pregnancy  
Fertility treatment  
Difficult pregnancy

**7. Birth Experience**

Birth experience

**8. Mothering Issues**

Stressed  
Demands of children  
Sibling rivalry  
Sick children/ colicky

Breastfeeding  
Separation anxiety from baby  
Failure as a mother  
Unrealistic expectations  
Overwhelming responsibility/ dependency  
Lack of acknowledgement  
Mask of motherhood  
No attachment to baby  
Disappointed in looks of child

**9. Sleep Issues**

Sleeping issues  
Exhaustion

**10. Work Issues**

Missed work  
Lonely/ isolated  
Loss of job  
Work stress  
Professional dilemma  
Juggling roles (mom/wife/career)  
Housework

**11. Predisposition**

Personal history of depression  
Family history of depression  
Hormonal/ biochemical  
Thyroid problem

**12. Personality Factors**

Personality factors  
Caretaker  
Strong persona  
Control

**13. Stressors**

Family stressors  
Stressors  
Financial stress  
Cat died

# APPENDIX 4

## TABLE OF RESPONDENTS ATTRIBUTIONS OF CAUSE

	S 1	S 2	S 3	S 4	S 5	S 6	S 7	S 8	S 9	S 10	S 11	S 12	S 13	S 14	S 15	S 16	S 17	S 18	S 19	S 20	Total
Lack of Support		1			1		1	1		1			1		1				1		8
Relationship with Partner	1				1	1	1	1		1		1			1				1		9
Own Mother	1	1	1	1		1	1	1	1	1	1		1				1			1	13
Unresolved Issues	1	1	1	1	1		1				1		1	1	1		1	1		1	13
Loss	1			1		1		1	1		1	1							1	1	9
Pregnancy	1	1																		1	3
Birth Experience	1			1				1		1		1	1	1	1	1		1		1	11
Mothering Issues		1	1		1	1		1	1	1	1	1	1	1	1			1	1	1	15
Sleep Issues		1		1	1	1		1	1		1							1	1	1	10
Work Issues	1		1	1	1	1	1		1	1	1	1		1			1	1			13
Predisposition	1	1	1	1	1	1	1					1	1		1		1	1		1	13
Personality Factors	1	1	1	1	1	1			1			1		1		1		1		1	12
Stressors	1		1					1		1			1	1					1	1	8
Total	10	8	7	8	8	8	6	8	6	7	6	7	7	6	6	2	4	7	6	10	



**APPENDIX 5****ASSIGNED NAMES OF PARTICIPANTS**

<b>S1</b>	Natalie	<b>S11</b>	Sandra, Joshua*
<b>S2</b>	Betty	<b>S12</b>	Gaby, Liam*
<b>S3</b>	Carla, Michelle*	<b>S13</b>	Debby
<b>S4</b>	Fiona	<b>S14</b>	Nicky
<b>S5</b>	Sharon	<b>S15</b>	Elaine, Nina*
<b>S6</b>	Patty	<b>S16</b>	Wendy
<b>S7</b>	Vanessa	<b>S17</b>	Belinda
<b>S8</b>	Rachel, Sarah*	<b>S18</b>	Heidi
<b>S9</b>	Ilana	<b>S19</b>	Jessie
<b>S10</b>	Lucy, Daniel*, Stephanie*	<b>S20</b>	Amanda, Michael*

\* assigned name of child/ren

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